

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
10406 **CERTIFICATE OF DEATH**
 FOR MEDICAL EXAMINERS

Pd

10381

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Hanna)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	
TOWN _____		TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 126 Ridge Road</u>		STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>Adamski</u> (Last) <u>Adamski</u>		4. DATE OF DEATH <u>Nov. 14</u> 19 <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov-17-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>radio repair</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE last birthday <u>62</u> yrs. If under 1 year: Months _____ Days _____ If under 24 hrs.: Hours _____ Mins. _____
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carroll Adamski</u>		14. MOTHER'S MAIDEN NAME <u>Valerie Wazowski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>215-01-3062</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C. Adamski - (Wife)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) _____ Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY _____ (CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____	
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? _____	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Clara D. Adamski</u> (Degree or title) <u>Medical Examiner - Glen Burnie, Md.</u>		DATE SIGNED <u>11/14/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>Nov 17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Lawrence</u>		LOCATION (City, town, or county) <u>Greenbelt BC Md</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>Nov. 16, 1955</u>		24. FUNERAL DIRECTOR <u>Benard A. Frank</u> ADDRESS <u>Glen Burnie Md</u>	

L. J. Deacha.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10382

10407 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		LENGTH OF STAY (in this place) <u>2 yrs</u>		OR TOWN <u>Severna Park</u>		OR TOWN <u>Severna Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MD.</u>				STREET ADDRESS (If rural give location) <u>143 Boone Trail</u>			
3. NAME OF DECEASED (First) <u>EVA</u> (Middle) <u>W.</u> (Last) <u>ASHTON</u>				4. DATE OF DEATH (Month) <u>NOV</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>OCT 25, 1875</u>	
9. AGE last birthday <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Hopkerville MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL HOOPER</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN MECKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Daughter in Law, Mrs Ruark, Severna Park</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>① Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>② Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>16 Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1 Nov</u> , 19 <u>55</u> , and that death occurred at <u>2 P</u> .M, from the causes and on the date stated above. <u>16 Nov 55</u>							
SIGNATURE <u>R. Holm</u> M.D.				ADDRESS (Street, city, town, state) <u>Severna Park MD</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>13</u>		DATE THEREOF <u>11-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		LOCATION (City, town, or county) (State) <u>BALTO</u>	
24. REC'D BY REGISTRAR <u>NOV 18 1955</u>		REGISTRAR'S SIGNATURE <u>Louis J. DeAlto</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>1700 11th FUNERAL HOMES</u>			
DATE		ADDRESS <u>130 E. TENT AVE.</u>					

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10383

10408

CERTIFICATE OF DEATH

Item 7, FilmG189 12-2-55 et

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If rural give location)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN <u>Baltimore</u>		31014	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		PLAZA MANOR CONV. Home		513 W. Biddle ST. v	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
JOHN BARBER				Nov 24		19 55	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
M		C		Widowed		Nov. 4.	
9. AGE (at birth)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
74 yrs.		Laborer		Unknown		Unknown	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
9						Plaza Manor Conv. Home	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A)						Cerebro-vascular	
ANTECEDENT CAUSE(S) DUE TO						accident	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						Arteriosclerosis general	
STATING UNDERLYING CAUSE LAST. DUE TO						Arteriosclerotic heart disease	
19. DATE OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 19 55, to Nov 19 55, that I last saw the deceased alive on Nov 23, 19 55, and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Jeph Tabor				162 Balto. Annap. Blvd. <u>Baltimore, Md.</u>		Nov. 26, 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11-26-55		Mt. Zion Cem		Balto - Co. and.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Nov 28, 1955		Louis J. DeAlba		Wm. G. Jackson Funeral Home		916 Penna ave	

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MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Form 100-101

1. NAME OF DECEASED (Last, first, middle initial)

2. PLACE OF DEATH

3. SEX (Male or Female)

4. RACE

5. DATE OF DEATH

6. TIME OF DEATH (Hour, minute)

7. PLACE OF BIRTH

8. AGE (Years, months, days)

9. OCCUPATION

10. CAUSE OF DEATH (Immediate)

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. DATE OF REGISTRATION

15. PLACE OF INTERMENT

16. NAME OF INTERMENT PLACE

17. GRAVE NUMBER

18. REMARKS

19. SIGNATURE OF DECEASED

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

0379 CERTIFICATE OF DEATH

10384

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Davidsonville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location)			
63				1			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>PHILIP Philip W. BEARD</u>				<u>NOVEMBER 6 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	September 23, 1907	48 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. (trouble man) Gas & Elect</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Lynchburg, Va.</u>		<u>USA</u>
13. FATHER'S NAME <u>ROBERT P BEARD</u>				14. MOTHER'S MAIDEN NAME <u>LILA PRIEST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-5626</u>		17. INFORMANT & ADDRESS <u>Mrs Doris Beard- Wife- same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
195X IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSION</u>						<u>5 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>METASTATIC PHEOCHROMOCYTOMA</u>						<u>2 YRS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11/6</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11/6</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/6</u> , 19 <u>54</u> , to <u>11/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>55</u> , and that death occurred at <u>5 P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Beck</u>				ADDRESS (Street, city, town, state) <u>41 Southgate Ave Annapolis</u>		DATE SIGNED <u>11/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	
DATE <u>11-9-55</u>							

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON CERTIFICATE OF DEATH

10884

DATE OF DEATH

LOCAL RESIDENT OR VISITOR

PLACE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 CAUSE OF DEATH
 MANNER OF DEATH
 MEDICAL HISTORY
 PRESENT ILLNESS
 DATE OF ONSET
 DATE OF DEATH
 PLACE OF DEATH
 NAME OF PHYSICIAN
 NAME OF HOSPITAL
 NAME OF NURSE
 NAME OF ATTENDING PHYSICIAN
 NAME OF PATHOLOGIST
 NAME OF CORONER
 NAME OF JURY
 NAME OF JUDGE
 NAME OF CLERK
 NAME OF REGISTRAR
 NAME OF ASSISTANT REGISTRAR
 NAME OF CLERK
 NAME OF REGISTRAR
 NAME OF ASSISTANT REGISTRAR

DATE OF DEATH
 PLACE OF DEATH
 NAME OF PHYSICIAN
 NAME OF HOSPITAL
 NAME OF NURSE
 NAME OF ATTENDING PHYSICIAN
 NAME OF PATHOLOGIST
 NAME OF CORONER
 NAME OF JURY
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 NAME OF REGISTRAR
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 NAME OF CLERK
 NAME OF REGISTRAR
 NAME OF ASSISTANT REGISTRAR

BUREAU V. 2

NOV 14 1935

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH TO BE FURNISHED TO THE LOCAL HEALTH OFFICE BY THE REGISTRAR OF DEATHS, MASSACHUSETTS, ON THE DAY FOLLOWING THAT OF THE DEATH. THE LOCAL HEALTH OFFICE SHALL BE ADVISED OF THE DEATH OF EVERY PERSON WHO DIES IN THE STATE, AND OF THE CAUSE OF DEATH, AND OF THE PLACE OF DEATH, AND OF THE NAME OF THE PHYSICIAN, AND OF THE NAME OF THE HOSPITAL, AND OF THE NAME OF THE NURSE, AND OF THE NAME OF THE ATTENDING PHYSICIAN, AND OF THE NAME OF THE PATHOLOGIST, AND OF THE NAME OF THE CORONER, AND OF THE NAME OF THE JURY, AND OF THE NAME OF THE JUDGE, AND OF THE NAME OF THE CLERK, AND OF THE NAME OF THE REGISTRAR, AND OF THE NAME OF THE ASSISTANT REGISTRAR.

10409

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

R 10385

No. 20

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) DAVIDSONVILLE
 TOWN (in this place)

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel
 CITY (If outside corporate limits write RURAL and give nearest town) DAVIDSONVILLE
 TOWN

STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED: (First) (Middle) (Last)
DAVE W BELL
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
November 13 19 55

5. SEX: Male 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): DIV. 8. DATE OF BIRTH: NOV. 26, 1879 9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Painter 10b. KIND OF BUSINESS OR INDUSTRY: House 11. BIRTHPLACE (State or foreign country): Alabama 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

John W. Bell

14. MOTHER'S MAIDEN NAME:

Margaret Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no no

16. SOCIAL SECURITY No.: 217-07-6291

17. INFORMANT & ADDRESS:

Mr Eugene Albright- Maryland Ave., Annapolis, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) gun shot wound skull
 DUE TO

Antecedent cause(s) (b) gun shot wound skull
 Diseases or conditions, if any, giving rise to the above cause DUE TO

stating underlying cause last (c)

INTERVAL BETWEEN
 ONSET AND DEATH
1 hour

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 11-13-55 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) Ad Co (County) Ad Co (State) Ad Co

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 11 13 55 M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? gun shot wound

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John W. Bell

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 11-14-55
 DEPUTY MEDICAL EXAMINER ☒
 M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): Removal

DATE THEREOF 11-15-55

NAME OF CEMETERY OR CREMATORY to

LOCATION (City, town, or county) Chattanooga, Tenn. (State)

DATE REC'D BY LOCAL REG. Nov. 15, 1955

REGISTRAR'S SIGNATURE John W. Bell

24. FUNERAL DIRECTOR Hopping Funeral Home

ADDRESS Annapolis, Md

Rec'd 11-17-55

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10382

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-354610)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]

Re New York letter to Bureau dated 10/21/55.

On 10/21/55, [Illegible]

RE

100-354610

Enclosure

100-354610

Very truly yours,
[Illegible Signature]

100-354610

Enclosure - 100-354610

BUREAU V. 1

10V 21 1955

RECEIVED

100-354610

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10380

CERTIFICATE OF DEATH

10386

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNE APOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNE APOLIS</u>		TOWN <u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 GREENFIELD ST</u>				STREET ADDRESS (If rural give location) <u>14 GREENFIELD ST</u>			
3. NAME OF DECEASED (Type or Print) <u>Oden</u> (First) <u>Bowie</u> (Middle) <u>Bowie</u> (Last)				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>5</u>	8. DATE OF BIRTH <u>4-15-1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY BOWIE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA BOWIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>BATHER CREEK ANN MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>148X</u>				<u>Carcinoma of throat, metastases</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>4-4</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-4</u> , 19 <u>55</u> , to <u>11-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-12-55</u> , 19 <u>55</u> , and that death occurred at <u>8-AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ann T. Allen</u>		M.D. <u>62</u>		ADDRESS (Street, city, town, state) <u>Croftwood</u>		DATE SIGNED <u>11-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-16-55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood Hill</u>		LOCATION (City, town, or county) (State) <u>ANNE APOLIS MD</u>	
24. REC'D BY REGISTRAR <u>Wm. J. French</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>103 Washington St</u>	
DATE <u>Nov. 15, 1955</u>							

Ann Apolix MD

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE WHEN DECEASED

10000

10000

10000

10000

10000

10000

10000

10000

BUREAU V. S.

NOV 16 1955

RECEIVED

10000

10410 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>MAGOTHY BEACH</u>				CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Magothy Beach</u>			
LENGTH OF STAY (in this place) <u>5 YEARS</u>				TOWN <u>Magothy Beach</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverside Drive</u>				STREET ADDRESS (If rural give location) <u>Riverside Drive</u>			
3. NAME OF DECEASED: (First) <u>MARY</u> (Middle) <u>ELIZABETH</u> (Last) <u>BUNCH</u>				4. DATE OF DEATH: (Month) <u>Nov.</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>May 22, 1888</u>	
9. AGE last birthday: <u>67</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Packer</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>CYRUS BECK</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Ada Ford - Magothy Beach</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
<u>443X</u> Immediate cause (a) <u>CEREBRAL HEMORRHAGE</u>				<u>2 days</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u>				<u>4 years</u>			
(c) <u>Arteriosclerotic Cardio Vascular Disease</u>				<u>4 years</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20</u> , 19 <u>55</u> , to <u>11/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>55</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Brady Smith M.D.</u> (Degree or title)				ADDRESS <u>Riverside Beach, Md.</u> DATE SIGNED <u>11/23/55</u>			
23. BURIAL, CREMATION, REINTERMENT (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/26/55</u>		<u>Oak Lawn Cemetery</u>		<u>Baltimore Co., Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>11-25-55</u>		<u>[Signature]</u>		<u>Wm. Gork. Inc.</u>		<u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2501

11/2/40

10/1/40

10/1/40

10/1/40

10/1/40

10/1/40

10411 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - PASADENA P.O.</u> LENGTH OF STAY (in this place) <u>80 years</u> TOWN <u>RURAL - PASADENA P.O.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BAYSIDE & BELHAUVEN ROAD</u>		STATE <u>MARYLAND</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - PASADENA P.O.</u> TOWN <u>RURAL - PASADENA P.O.</u> STREET ADDRESS (If rural give location) <u>BAYSIDE & BELHAUVEN ROAD</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>SUSANNA LANE CARROLL</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>NOV - 2 19 55</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>MARCH 16, 1869</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>	9. AGE last birthday: <u>86</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>GEORGE WASHINGTON KESS</u>		14. MOTHER'S MAIDEN NAME: <u>MARY ANN OWENS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>THELMA KELLY (DAUGHTER) JACOBSTOWN, MD</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset and Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cornary Thrombosis</u>		<u>2 days</u>
Antecedent causes (s) (b) <u>Arteriosclerotic Cardio Vascular Disease</u>		<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Diabetes Mellitus</u>		<u>10 years</u>

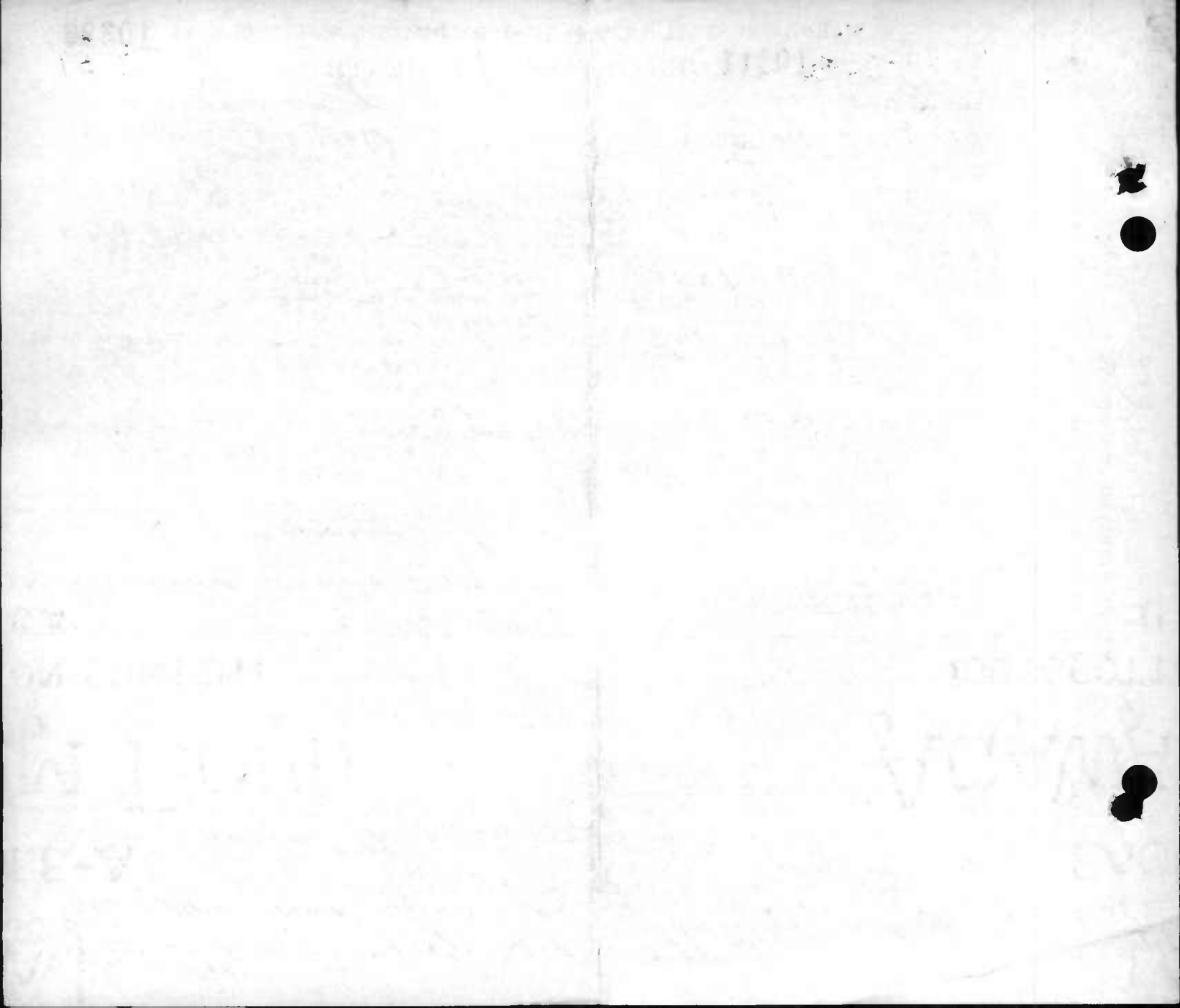
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY, 1946, to NOV. 2, 1955, that I last saw the deceasedalive on 10/31, 1955, and that death occurred at 8:20 PM; from the causes and on the date stated above.SIGNATURE J. Brady Smith (Degree or title) M.D. ADDRESS RIUIER BEACH, MD DATE SIGNED 11/2/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>11/6/55</u>	<u>MT. ZION CHURCH CEM.</u>	<u>MAGOTHY - A.A.CO. MD.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>11/8/55</u>	<u>U.W. Hedrick</u>	<u>Marshall P. Hayes</u>	<u>638 N. GILMORE ST BALTO. MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10389

10381 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>WOODLAND BEACH</u>				TOWN <u>WOODLAND BEACH</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. General</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY</u> <u>R.</u> <u>CARTER</u>				<u>NOV.</u> <u>7</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE at birth	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>W</u>	<u>Aug-20-1880</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housewife</u>		<u>Home</u>		<u>Va</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Johnson</u>				<u>Mary V. Pote</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Y</u>		<u>-</u>		<u>William E. Oliver</u> <u>(2)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>						<u>None</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						<u>10 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUGUST, 1955</u> , to <u>OCTOBER, 1955</u> , that I last saw the deceased alive on <u>OCTOBER 10, 1955</u> , and that death occurred at <u>10:35</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John L. Hederman</u> M.D.				ADDRESS (Street, city, town, state) <u>90 Cathedral St. Annapolis, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-10-55</u>		<u>Bedard Hill</u>		<u>Annapolis Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov. 9, 1955</u>		<u>J. J. Daniel</u>		<u>John W. Taylor</u>		<u>Cons Annapolis Md</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10390

10412 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>32 days</u>		TOWN <u>Baltimore City</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Henry</u>		(Middle) <u>Chavers</u>		(Last)			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Unk.</u>		8. DATE OF BIRTH <u>Unk.</u>	
9. AGE last birthday <u>60?</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>-</u> Days <u>-</u>		Months <u>-</u> Days <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION				19. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Brain Tumor</u>				<u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bilateral Bronchopneumonia, Syphilis</u>							
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>-</u> <u>-</u> <u>-</u> <u>-</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u> <u>-</u> <u>-</u>			
22. I hereby certify that I attended the deceased from <u>10/7</u> , 19 <u>55</u> , to <u>11/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>55</u> , and that death occurred at <u>12:45 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Hildegard Heard Reinmann</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE <u>11-14-55</u>				DATE SIGNED <u>11/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hospital</u>		LOCATION (City, town, or county) (State) <u>Crownsville, Maryland</u>	
24. REC'D BY REGISTRAR <u>KM-Joyce</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold H. Eichert, M. D. Crownsville, Md.</u>		ADDRESS	

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10391

10413 **CERTIFICATE OF DEATH**Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u>		COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Severna Park</u>		<u>46 yrs</u>		TOWN <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>100 Jumpers Hole Rd.</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Reuben Clapton</u>				<u>11-21-55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>C.</u>		<u>1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Farmer</u>		<u>Farm</u>		<u>Va.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>						<u>Wife Ethel Clapton</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.1 IMMEDIATE CAUSE</u>				<u>Myocardial Infarction</u>			
<u>ANTECEDENT CAUSE(S)</u>				<u>Generalized arteriosclerosis</u>			
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>							
<u>STATING UNDERLYING CAUSE LAST.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1955</u> , to <u>Nov 1955</u> , that I last saw the deceased alive on <u>2 Nov 1955</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		DATE SIGNED	
<u>R. Holm</u>		<u>11-25-55</u>		<u>1st Baptist</u>		<u>21 Nov 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>L. J. Debel</u>		<u>William Reese, Jr</u>		<u>Annapolis, Md</u>	
DATE		REGISTRAR'S SIGNATURE		ADDRESS			
<u>Nov. 29, 55</u>							

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10392

10392 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>15 hrs.</u>		STREET ADDRESS (If rural give location) <u>Green Gables, Mountain Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp.</u>				STREET ADDRESS <u>Green Gables, Mountain Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Pauline Cox</u>				4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 4, 1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Fred W. Messer</u>				14. MOTHER'S MAIDEN NAME <u>Susan Kuhn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Frederick W. Cox, Sr. 924 Light St. Baltimore, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Gen. arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-7</u> , 19 <u>55</u> , to <u>11-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-7</u> , 19 <u>55</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>South Pooler</u>				ADDRESS (Street, city, town, state) <u>45 Franklin St. Annapolis, Md.</u> DATE SIGNED <u>11-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>Nov. 11, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. S.

NOV 16 1955

RECEIVED

NOTIFICATION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10393

10414

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH Crownsville COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED Maryland COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings, Maryland</u> STREET ADDRESS (If rural give location) <u>04X-2</u>	
3. NAME OF DECEASED (Type or Print) <u>Wesley</u> (First) <u>Curtis</u> (Middle) <u></u> (Last)		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct. 28, 1869</u>
9. AGE last birthday <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mason Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Howell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>?</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Eurbia Curtis</u> <u>Harry Hutchings</u> <u>Owings Maryland</u>		Phone North Beach <u>4538</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>455X</u> IMMEDIATE CAUSE (A) <u>Pulmonary Embolus</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Recent Amputation of left leg</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Gangrene of toe</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congestive Heart Failure</u>			
19a. DATE OF OPERATION <u>Oct. 17, 1955</u> <u>Oct. 20, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Right Lumbar Sympathectomy</u> <u>Left Midhigh Amputation</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21a. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21b. HOW DID INJURY OCCUR?	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that, attended the deceased from <u>11/2/57</u> , 19 <u>58</u> , to <u>11/5/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/5/55</u> , 19 <u>55</u> , and that death occurred at <u>11/5/55</u> , M., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>11/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>11/14/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hospital</u>		LOCATION (City, town, or county) (State) <u>Crownsville Md.</u>	
24. REC'D BY REGISTRAR <u>R. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold N. Eckhart, M.D.</u> ADDRESS <u>Crownsville, Md.</u>	
DATE <u>11-14-55</u>		per trunk	

BUREAU. V. S.

NOV 16 1955

RECEIVED

11-12-1941 K. M. Foster

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10395

10383 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A. A.</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>A. A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <i>Annapolis</i>				10 TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A. A. General</i>				STREET ADDRESS (If rural give location) <i>6 St Mary's</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Nina May Dawes</i>				<i>11-27-1955</i>			
5 SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>4-7-1897</i>	9. AGE last birthday <i>58</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Crownsville Md.</i>	
13. FATHER'S NAME <i>Robert P. Stevens</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS <i>John M. Dawes Jr. ②</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <i>Pulmonary Embolism</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardiovascular</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 23</i> , 19 <i>53</i> , to <i>11-27</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Nov 23</i> , 19 <i>55</i> , and that death occurred at <i>1:55</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>John M. Dawes Jr.</i>				ADDRESS (Street, city, town, state) <i>Annapolis Md.</i>		DATE SIGNED <i>11-27-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11-27-55</i>		NAME OF CEMETERY OR CREMATORY <i>St Annes</i>		LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. O. Daniel</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>	
DATE <i>Nov. 28, 1955</i>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10394 CERTIFICATE OF DEATH

10396

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND		STATE <u>MD</u> COUNTY <u>A. A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Harwood</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homeewood Convalescent Home</u>							
3. NAME OF DECEASED (First) (Middle) (Last) <u>Gertrude</u> <u>Dawson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 5</u> <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAY 28 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CHURCHTON MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS H PHIPPS</u>				14. MOTHER'S MAIDEN NAME <u>CINDERELLA PERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 30</u> , 19 <u>55</u> , to <u>Nov 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 4</u> , 19 <u>55</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilkin</u> M.D.				ADDRESS (Street, city, town, state) <u>Lothian MD</u>		DATE SIGNED <u>11/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov 8 1955</u>		NAME OF CEMETERY OR CREMATORY <u>MT ZION Cem.</u>		LOCATION (City, town, or county) (State) <u>LOTHIAN MD</u>	
24. REC'D BY REGISTRAR <u>Nov. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR - SON</u>		ADDRESS <u>ANNAPOLIS MD</u>	

SECRET

BUREAU V. S.

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RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10415 CERTIFICATE OF DEATH

10397

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>4 yrs. 2 mos. 2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>908 N. Shuter Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Julia Downing</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 27 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11/14/49</u>	9. AGE last birthday <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u>		IF UNDER 24 HRS. Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Levin Downing</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>002X</u> IMMEDIATE CAUSE (A) <u>Hypostatic Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Known to us</u> <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congenital Internal Hydrocephalus</u>						Since birth	
19a. DATE OF OPERATION <u>11-25-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Enucleation of right eye</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>- - - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - - - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>- - - - - M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>- - - - -</u>			
22. I hereby certify that I attended the deceased from <u>9/25</u> , 19 <u>51</u> , to <u>11/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Stanley C. Sargeant</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE SIGNED <u>11/28/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		LOCATION (City, town, or county) (State) <u>A. A. County, Md</u>	
24. REC'D BY REGISTRAR <u>Mr. J. M. Joyce</u>		REGISTRAR'S SIGNATURE <u>Mr. J. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Robert A. Elliott & Daugherty</u>		ADDRESS <u>- - - - -</u>	

100-100000

10015 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

10891

Reg. No. 100

ALL INFORMATION HEREON IS UNCLASSIFIED

DATE 11/11/00 BY SP-10/11/00

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BUREAU V. S.

NOV 30 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10385

CERTIFICATE OF DEATH

10398

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Annapolis</u>		<u>3 yrs.</u>		TOWN <u>Baltimore</u>		<u>3701-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3218 Lyndale Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>JACOB EBERHARDT</u>				<u>Nov. 11th, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>April 26, 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>grave digger</u>			<u>cemetery</u>		<u>Balto., Md.</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>E. F. Lassahn, 7401 Belair Rd., Balto. 6</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u></u>							<u>1 HOUR</u>
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u></u>							<u>UNKNOWN</u>
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/7/55</u>, 19<u>55</u>, to <u>11/11</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/7</u>, 19<u>55</u>, and that death occurred at <u>1:22</u> M, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Edward L Beck</u>		<u>11/12/55</u>		<u>Baltimore Cemetery</u>		<u>Baltimore, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>burial</u>		<u>Nov. 14, 1955</u>		<u>Wm. J. French</u>		<u>Lassahn Funeral Home 7401 Belair Rd.</u>	

10350

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

10350 CERTIFICATE OF DEATH

10350

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. DATE OF BIRTH

4. SEX

5. OCCUPATION

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. DATE OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESS

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

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91. SIGNATURE OF JURY

92. SIGNATURE OF JUDGE

BUREAU V. S.

NOV 14 1955

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10350

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10416

CERTIFICATE OF DEATH

10399

Reg. Dist. No. 24

Items 8, 9, 11, 13, 14, 10a

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>JOINT PLEASANT</u>				TOWN <u>JOINT PLEASANT.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shoreland Dr.</u>				STREET ADDRESS (If rural give location) <u>Shoreland Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Ellis</u> (First) <u>Harry</u> (Middle) <u>Edwards Jr</u> (Last)				4. DATE OF DEATH <u>11</u> (Month) <u>20</u> (Day) 19 <u>55</u> (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>1-6-81</u>		9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ward Baking Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Virginia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Family - Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u> <u>at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 19 55</u> to <u>Nov 19 55</u> , that I last saw the deceased alive on <u>11-20</u> , 19 <u>55</u> , and that death occurred at <u>5:20</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>E. McCollum M.D.</u>		DATE THEREOF <u>11-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>130 E. FORT AVE.</u>		DATE SIGNED <u>11-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>13</u>		24. DECD BY REGISTRAR <u>Nov 23, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McCully FUNERAL HOMES</u>		ADDRESS <u>130 E. FORT AVE.</u>	

NOTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN DECEASED AND THAT THE DEATH HAS BEEN REPORTED TO THE LOCAL HEALTH DEPARTMENT BY THE PERSON WHOSE NAME IS PRINTED AT THE BOTTOM OF THIS CERTIFICATE. THE DEATH OF THIS PERSON IS BEING REPORTED TO THE LOCAL HEALTH DEPARTMENT BY THE PERSON WHOSE NAME IS PRINTED AT THE BOTTOM OF THIS CERTIFICATE. THE DEATH OF THIS PERSON IS BEING REPORTED TO THE LOCAL HEALTH DEPARTMENT BY THE PERSON WHOSE NAME IS PRINTED AT THE BOTTOM OF THIS CERTIFICATE.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10932

Reg. Dist. No.

1. LOCAL HEALTH DEPARTMENT OF THE PLACE

2. PLACE OF DEATH

3. SEX

4. NAME

5. NAME

Ellis Harry Edwards Jr

6. DATE

11 20 52

Coronary Hemorrhage
Hypertensive Heart Disease

1 001

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John Gunn

Nov 22 1955

11-20 11 52

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10417 CERTIFICATE OF DEATH

1040028

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (In this place) <u>8 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hollywood</u>		<u>18X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>None listed</u>			
3. NAME OF DECEASED (Type or Print) <u>Bertha</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 10 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>8/29/97</u>	
9. AGE last birthday <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> - - - </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Not listed Joseph H. Barber</u>				14. MOTHER'S MAIDEN NAME <u>Not listed Jane S. Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>153X</u> IMMEDIATE CAUSE (A) <u>Small bowel obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>August, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>carcinoma of small bowel obstruction</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u> M. <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>11/2</u>, 19<u>55</u>, to <u>11/10</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/10</u>, 19<u>55</u>, and that death occurred at <u>8:30aM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Edgard Heard</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>11/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hollywood, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>11-14-55</u>		REGISTRAR'S SIGNATURE <u>Th. M. Rogers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Robinson</u>		ADDRESS <u>Louisa</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10418

CERTIFICATE OF DEATH

10401

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>a a</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>a a</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>X</u>		LENGTH OF STAY (In this place) <u>30 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>DAVID HOWARD FOSTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 13 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 30 1892</u>		9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID M FOSTER</u>				14. MOTHER'S MAIDEN NAME <u>Florence F Yates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES 1910-1911</u>		16. SOCIAL SECURITY NO. <u>212-30-2339</u>		17. INFORMANT & ADDRESS <u>Molly U. Foster Lakesville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.0 Acute coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				SEVERAL YEARS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1955, to present, 1955, that I last saw the deceased alive on August 19, 1955, and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Edw. H. Hennrichs</u> M.D.				ADDRESS (Street, city, town, state) <u>Stady Side, Md.</u>		DATE SIGNED <u>Nov 15, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>		LOCATION (City, town, or county) <u>ARLINGTON VA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Collins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS	
DATE <u>NOV 18 1955</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10402

10386 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>AA</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>AA</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>301 N. TAYLOR AVE</u>		STREET ADDRESS <u>301 N. TAYLOR AVE</u>	
3. NAME OF DECEASED (Type or Print) <u>MADÉLINE J. FRANK</u>		4. DATE OF DEATH <u>Nov 24 19 55</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>JAN 8 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>59</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>SYRACUSE NY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Joseph C. Frank</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
416X IMMEDIATE CAUSE (A) <u>Cerebral embolism</u>		<u>24 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Auricular fibrillation</u>		<u>yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatic heart disease</u>		<u>yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>10/10/55</u> , 19 <u>52</u> , to <u>11/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/23/55</u> , 19 <u>55</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Frank M. Shibley</u>		DATE SIGNED <u>11/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>National</u>	
24. REC'D BY REGISTRAR <u>John M. Taylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>	
DATE <u>Nov. 28, 1955</u>		ADDRESS (Street, city, town, state) <u>Annapolis Md</u>	

10000

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1938 CERTIFICATE OF DEATH

Reg. Div. No. 100

1. Name of Deceased

2. Sex

3. Race

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Place of Death

8. Cause of Death

9. Duration of Illness

10. Name of Physician

11. Name of Hospital

12. Name of Undertaker

13. Name of Burial Place

14. Name of Funeral Home

15. Name of Cemetery

16. Name of Interment Place

17. Name of Burial Place

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1. Name of Deceased
2. Sex
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4. Date of Birth
5. Place of Birth
6. Date of Death
7. Place of Death
8. Cause of Death
9. Duration of Illness
10. Name of Physician
11. Name of Hospital
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97. Name of Burial Place
98. Name of Interment Place
99. Name of Burial Place
100. Name of Interment Place

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10403

10419 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>A. A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SEVERNA PARK (RURAL)</u>		<u>20 YRS</u>		TOWN <u>SEVERNA PARK (RURAL)</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RIVERSIDE DRIVE HOLLYWOOD SEVERN RIVERSIDE DRIVE, HOLLYWOOD ON SEVERN</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u>		(Middle) <u>HYDE</u>		(Last) <u>FROST</u>		(Month) (Day) (Year)	
<u>NOV 17</u>		<u>1955</u>					
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>OCT 27, 1876</u>	<u>79</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>HOUSE WORK (RETD) OWN HOME</u>			<u>OWN HOME</u>		<u>ST LOUIS, MO.</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHARLES HOLCOMB</u>				<u>BARBARA VON POLCROFT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>NONE</u>		<u>HOLLYWOOD ON SEVERN</u> <u>MRS HARRIET FONDA SEVERNA PARK MD</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
194X IMMEDIATE CAUSE (A) <u>Congestive Heart failure</u>						<u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA of Thyroid with metastasis</u>						<u>1 1/2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>to cervical glands & FACE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>NOV</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>NOV 11</u> , 19 <u>55</u> , and that death occurred at <u>130 P</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>Francis J. Cold</u> M.D.				ADDRESS (Street, city, town, state) <u>Box 289 SEVERNA PARK MD</u>		DATE SIGNED <u>Nov 13, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>NOV. 15, 1955</u>		<u>CHRISTIAN CHURCH CEM</u>		<u>CHARLESTON FOUR CORNERS, NY</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE Nov 17, 1953</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>[Address]</u>	

BUREAU V. S.

NOV 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10420 CERTIFICATE OF DEATH

10404

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-ANNE ARUNDEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-ANNE ARUNDEL</u>	
OR TOWN <u>RURAL-ANNE ARUNDEL</u>		LENGTH OF STAY (in this place)		OR TOWN <u>RURAL-ANNE ARUNDEL</u>		OR TOWN <u>RURAL-ANNE ARUNDEL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS <u>HOCKLEY HALL</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>FRANCIS LOUISE GANTT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 6th 1955</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>1-13-1865</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR (Months) (Days)		IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Maria Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>1910</u>		16. SOCIAL SECURITY NO. <u>1-10-55</u>		17. INFORMANT & ADDRESS <u>Anna Maria Parker-Hockley Hall</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Arteriosclerosis Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>July 15, 1955</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C) <u>Grade III</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> to <u>Nov 6, 1955</u> , that I last saw the deceased alive on <u>Nov 6, 1955</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>11/9/55</u>		ADDRESS (Street, city, town, state) <u>110-0141 Hockley Hall, Anne Arundel Co., Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Fowler</u>		LOCATION (City, town, or county) (State) <u>BESTGATE, Md</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II-108 Wash. ST</u>			
DATE <u>Nov. 14, 1955</u>		ADDRESS <u>ANNE ARUNDEL, Md</u>					

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

10000

Reg. Dist. No.

1. DECEASED PERSON'S NAME AND ADDRESS

2. PLACE OF DEATH

Married 25.00
Rural-Annapolis
Hockey Hall

3. SEX

Male

Rural-Annapolis

Francis Louise Gantt
1-13-1892
W
Domestic None
William Jenson
Mary Land
Annapolis
Annapolis - Hockey Hall

4. MEDICAL HISTORY

5. CAUSE OF DEATH

BUREAU V. 3

NOV 15 1955

RECEIVED

Best Gate, Md

General 11-25-55 Fowler

William Jenson
Annapolis Md
11-25-55

RECEIVED

10431
CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: <i>District Training School Hospital</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>ANNE Arundel</i>	MARYLAND	STATE <i>Washington County District of Columbia</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>X LAUREL</i>	LENGTH OF STAY (in this place) <i>1 yr - 9 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>WASHINGTON, D.C. 47X3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>11 District Training School LAUREL, MARYLAND</i>		STREET ADDRESS (If rural give location) <i>731-2nd St., N.E.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>CHARLES ROBERT GEORGE</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>11 - 10 1955</i>	
5. SEX: <i>MALE</i>	6. COLOR OR RACE: <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>SINGLE</i>	8. DATE OF BIRTH: <i>1-28-52</i>
9. AGE last birthday: <i>3 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>INMATE</i>	
11. BIRTHPLACE (State or foreign country): <i>WASHINGTON, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>William E. George</i>		14. MOTHER'S MAIDEN NAME: <i>VIRGINIA DOWNING</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No. <i>NONE</i>	
17. INFORMANT & ADDRESS: <i>Records of District Training School, LAUREL, Maryland</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>752X Congenital Hychocephalus</i>			<i>3 yrs 10 mo</i>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Anemia</i>			<i>1 mo</i>
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>15 Aug, 1955</i> to <i>10 Nov, 1955</i> , that I last saw the deceased alive on <i>10 Nov, 1955</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Francis M. Mashota</i>		DATE SIGNED <i>10 Nov 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>District Training School LAUREL, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Nov 14-55</i>		REGISTRAR'S SIGNATURE <i>Helara Haskins</i>	
24. FUNERAL DIRECTOR <i>Mrs John Noone</i>		ADDRESS <i>1078 Laurel</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 17 1955

BUREAU V. S.

10387
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 21

Reg. 10407

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>126 O'Berry Ct.</u>				STREET ADDRESS (If rural, give location) <u>126 O'Berry Ct.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>IRENE GREEN</u>				<u>NOV 14 19 55</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Female</u>	<u>col.</u>	<u>WIDOWED</u>	<u>1-29-1921</u>	<u>34</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic Days Work</u>		<u>Days Work</u>		<u>Mayo, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles E. Boston</u>				<u>Sessie Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>219-12-3514</u>		<u>Lena Stanton. 106 Clay St. Anns. Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u> sudden</u>	
Immediate cause (a) <u>420.1</u>		DUE TO <u>Chronic Renal</u>			
Antecedent cause(s) (b)		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>)		21c. (City or town) (County) (State)	
				<u>Anns</u> <u>red</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Thurman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/17/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>11-17-55</u>		<u>Braver Hill</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Nov. 17, 1955</u>		<u>U. Bravel</u>		<u>William Reese, Jr. 108 Wash. St. Annapolis, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 18 1955

RECEIVED

10422 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Same</u>		COUNTY <u>Same</u>	
CITY OR TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>40 years</u>		CITY OR TOWN <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Aquahart Rd.</u>				STREET ADDRESS <u>Same</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Anna</u> (First) <u>Griisser</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>November</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/24/79</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria-Hungary, Europe.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austrian.</u> ✓
13. FATHER'S NAME <u>Henry Muller</u>				14. MOTHER'S MAIDEN NAME <u>Anna Fait</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Miss. Catherine Griisser, (daughter).</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arterio sclerosis</u>						<u>10 y.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 1944, to <u>11/29</u> , 1955, that I last saw the deceased alive on <u>11/28</u> , 1955, and that death occurred at <u>12.05 A.M.</u> the causes and on the date stated above.							
SIGNATURE <u>Eustace H. Pauchard MD</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>11/29/55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>Brooklyn GACs Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. Datta</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Fink</u>		ADDRESS <u>Glen Burnie Md</u>	
DATE <u>Dec-1-1955</u>							

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

M TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

DEATH CERTIFICATE

Reg. Dis. No.

Place of Birth

Age

Sex

Color

Date

Time

Place

Place

Time

Place

Date

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BUREAU V. S.

DEC 2 1955

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Reg. Dist. No. 21

INSTRUCTIONS

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel	MARYLAND	STATE Maryland	COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR Annapolis	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 207 McKendree Ave.		STREET ADDRESS (If rural give location) 207 McKendree Ave	
3. NAME OF DECEASED (First) (Middle) (Last) MARIE CROLLMAN		4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 27 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH January 17, 1872
9. AGE last birthday 83 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Zorn		14. MOTHER'S MAIDEN NAME Augusta (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or <u>unk.</u>) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT & ADDRESS Mrs Sidney W. French- Daughter- # 2.		same as	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) MYOCARDIAL INSUFFICIENCY ANTECEDENT CAUSE(S) DUE TO (B) CORONARY VASCULAR DISEASE (ARTEROSCLEROSIS) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Senility		INTERVAL BETWEEN ONSET AND DEATH 3 wks. 13 d.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-20-55 , 19 55 , to 11-27-55 , 19 55 , that I last saw the deceased alive on 11-27-55 , 19 55 , and that death occurred at 1:30 M. from the causes and on the date stated above.			
SIGNATURE [Signature]		DATE SIGNED 11-28-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov 29 55	
NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR 11-28-55		25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS HOPPING FUNERAL HOME ANNAPOLIS, MD.	

10100

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1938 CERTIFICATE OF DEATH

DATE OF DEATH

1. USUAL RESIDENCE (HOUSE OR BUSINESS)

2. PLACE OF DEATH

3. NAME (Last, first, middle)

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. PERIOD OF ILLNESS

12. DATE OF DEATH

13. TIME OF DEATH

14. COUNTY

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF WITNESS

18. SIGNATURE OF DECEASED

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF WITNESS

22. SIGNATURE OF DECEASED

*Proposed by [illegible]
Charles - [illegible] (intermediate)*

Similarity

23. SIGNATURE OF DECEASED

BUREAU A. S.

11-30-32

11-30-32

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11-30-32

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A135 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10423 CERTIFICATE OF DEATH

10410

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>300 Nursery Rd</u>		LENGTH OF STAY (in this place) <u>434</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>North Linthicum</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Linthicum</u>				STREET ADDRESS (If rural give location) <u>300 Nursery Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Haber-korn - Frank a.</u>				4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>18,</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Mar.</u>	8. DATE OF BIRTH <u>Sept. 8 1861</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Freda ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Wife (Isabell Haber-korn)</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1 IMMEDIATE CAUSE (A) Cardio-Vascular Disease</u>				<u>6 mos.</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Arterio-Sclerosis</u>				<u>10-15 yrs.</u>			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DUE TO (C)							
19a. DATE OF OPERATION <u>11/18/55</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5</u> <u>11/18/55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/18/55</u> to <u>11/18/55</u> , that I last saw the deceased alive on <u>11/18/55</u> , 19 <u>55</u> , and that death occurred at <u>5</u> <u>PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball</u>				ADDRESS (Street, city, town, state) <u>Linthicum Md.</u>			
DATE <u>11/18/55</u>				DATE SIGNED <u>11/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Nov. 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 22 1955</u>		REGISTRAR'S SIGNATURE <u>Caldwell Goodruff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>			
DATE				ADDRESS <u>4001 Ritchie Hgwy.</u>			

1915 CERTIFICATE OF DEATH

10110

1. DEATH OF DECEASED (NUMBER OF THIS CASE)

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3. DEATH OF DECEASED (NUMBER OF THIS CASE)

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NOV 22 1955

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INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10389 CERTIFICATE OF DEATH

10411

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>8 yrs</u>		TOWN <u>Annapolis,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>3 Annapolis Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>LYDA</u> <u>HERR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 3</u> <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 26, 1868</u>		9. AGE last birthday <u>87</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Shepherdstown, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Rush</u>				14. MOTHER'S MAIDEN NAME <u>LYDA Rush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr Walter E. Herr, Son same as # 2</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis, generalized</u>				<u>1 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>				<u>1 yr.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-2-</u>, 19 <u>55</u>, to <u>11-3-</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>11-3-</u>, 19 <u>55</u>, and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Walter E. Herr</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md</u>		DATE SIGNED <u>11-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		LOCATION (City, town or county) (State) <u>Shepherdstown, West Virginia</u>	
24. REC'D BY REGISTRAR <u>11-3-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD</u>	

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11-5-77 22-11-3-77

Handwritten signature: *Handwritten signature*

11-3-11
James A. [unclear]



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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10390 CERTIFICATE OF DEATH

10412

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>10</u>				TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location)			
57 <u>Annapolis, Maryland</u>				402 Adams St., East Port, Anna., Md.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Karen Louise HOFFMAN</u>				<u>Nov. 23 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>White</u>	<u>Single</u>	<u>22 November 1955</u>		Months	Days	Hours Min.
						<u>1</u>	<u>3</u> <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Newborn</u>		<u>---</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Alfred HOFFMAN</u>				<u>Wanda Louise YOUNG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Y/N</u>		<u>None</u>		<u>Hospital Records & Family</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
776x IMMEDIATE CAUSE (A) <u>Immaturity with prematurity</u>						774 <u>1day&3hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>22 Nov.</u> , 19 <u>55</u> , to <u>23 Nov.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>23 Nov.</u> , 19 <u>55</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>John I. Egan, Jr.</u>				U.S. Naval Hospital (Street, city, town, state)			
JOHN I. EGAN, JR.				M.D. <u>Annapolis, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Forest Cemetery</u>		<u>Circleville, Ohio</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-25-55</u>		<u>10 - U. Egan</u>		<u>HOPPING FUNERAL HOME</u>		<u>ANNAPOLIS, MD</u>	

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REPORT

1. This report is to be filled out by the physician or other person who has attended the deceased, or by the person who has been in attendance at the death, or by the person who has been in attendance at the funeral, or by the person who has been in attendance at the burial, or by the person who has been in attendance at the cremation, or by the person who has been in attendance at the interment, or by the person who has been in attendance at the other disposition of the remains.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

10012

MD. REG. NO. 51

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCASION

7. DATE

8. TIME

9. CAUSE

10. MANNER

11. SIGNATURE

12. DATE

13. TIME

14. SIGNATURE

15. DATE

16. SIGNATURE

17. DATE

18. SIGNATURE

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41. DATE

42. SIGNATURE

43. DATE

44. SIGNATURE

45. DATE

BUREAU V. S.

NOV 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10391 CERTIFICATE OF DEATH

10413

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>AA</u>	MARYLAND	STATE <u>Mo.</u>	COUNTY <u>AA</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>94 MARKET</u>		STREET ADDRESS <u>94 MARKET</u>	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>SARAH</u> (Middle) <u>H.</u> (Last) <u>Hobbsday</u>		(Month) <u>Nov</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>July 24, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>84</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles King</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>John B. Hobbsday Jr. #2</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
443X IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Left Side - Hemiplegia</u>			<u>about 2 months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterial Hypertension</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 18, 1955</u> , to <u>Nov 13, 1955</u> , that I last saw the deceased alive on <u>Nov 12, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John B. Hobbsday Jr.</u>		ADDRESS (Street, city, town, state) <u>Annapolis Md</u>	
DATE SIGNED <u>11-14-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>11/15/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>	LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>John M. Lytle + Sons</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lytle + Sons</u>	ADDRESS <u>Annapolis, Md.</u>
DATE <u>Nov. 15, 1955</u>			

(1952) CERTIFICATE OF DEATH

Form No. 10-52

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female) ☐ Male ☐ Female

3. AGE (Years and Months) Years Months

4. DATE OF BIRTH (Month and Day) Month Day

5. PLACE OF BIRTH (City and State) City State

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. MANNER OF DEATH (Print or Write)

9. SIGNATURE OF PHYSICIAN (Print or Write)

10. SIGNATURE OF REGISTRAR (Print or Write)

11. SIGNATURE OF WITNESS (Print or Write)

12. SIGNATURE OF DECEASED (Print or Write)

13. SIGNATURE OF NEXT OF KIN (Print or Write)

14. SIGNATURE OF CLERK (Print or Write)

15. SIGNATURE OF CHURCH CLERK (Print or Write)

16. SIGNATURE OF MINISTER (Print or Write)

17. SIGNATURE OF RABBI (Print or Write)

18. SIGNATURE OF OTHER (Print or Write)

19. SIGNATURE OF OTHER (Print or Write)

20. SIGNATURE OF OTHER (Print or Write)

BUREAU V. S.

NOV 17 1955

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1. This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the Registrar of the State Department of Health. It is to be used for the purpose of determining the cause of death and for the purpose of determining the manner of death. It is to be used for the purpose of determining the date of death and for the purpose of determining the place of death. It is to be used for the purpose of determining the occupation of the deceased and for the purpose of determining the signature of the deceased. It is to be used for the purpose of determining the signature of the next of kin and for the purpose of determining the signature of the church clerk. It is to be used for the purpose of determining the signature of the minister and for the purpose of determining the signature of the rabbi. It is to be used for the purpose of determining the signature of the other person authorized by the State Department of Health.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

1 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10424 CERTIFICATE OF DEATH

10414

Reg. Dist. No. 24

1. PLACE OF DEATH <i>Glen Burnie</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>X</i> <i>Glen Burnie</i>		<i>all his life</i>		TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Charles Carroll Raygood Hoy</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov. 16, 1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1887 July 4, 1887</i>	9. AGE last birthday <i>68 yrs.</i>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Genl. Dr. H. C.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Genl. Dr. H. C.</i>		11. BIRTHPLACE (State or foreign country) <i>Balti. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John J. Hoy</i>				14. MOTHER'S MAIDEN NAME <i>Harriet Ellarode</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-28-9347</i>		17. INFORMANT & ADDRESS <i>Mrs. Carroll Hoy</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <i>Cardio-Vascular Disease</i>						10 years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Faster than</i>						20 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from....., 1945, to....., 1955, that I last saw the deceased alive on....., 1955, and that death occurred at....., 9..... A.M., from the causes and on the date stated above.							
SIGNATURE <i>James S. Bellinger</i>				ADDRESS (Street, city, town, state) <i>108 Central Ave. Glen Burnie Md. 21061</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>Nov. 19 1955</i>		NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN</i>		LOCATION (City, town, or county) (State) <i>GLEN BURNIE MD</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Doughton</i>		ADDRESS <i>Glen Burnie, Md</i>	
DATE <i>Nov 23, 1955</i>							

10294 CERTIFICATE OF DEATH

10211

Form 100-10-10

1. FULL NAME OF DECEASED

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MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 10
10294 CERTIFICATE OF DEATH
Form 100-10-10

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10415

10425

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>aa</u> MARYLAND CITY <u>Friendship</u> (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Friendship</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Friendship</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>aa</u> CITY <u>Friendship</u> (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Friendship</u> STREET ADDRESS <u>Friendship</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <u>Marlin Luther</u> (Middle) <u>Hutchins</u> (Last) <u>Hutchins</u>				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>June 14, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Grocery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Hutchins</u>				14. MOTHER'S MAIDEN NAME <u>Jane Owings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Winfield Hutchins Owings</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u> IMMEDIATE CAUSE (A) <u>arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____							
DUE TO _____ (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Found dead in bed at 1205 Ave</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Home aa MD</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR? <u>Found dead in bed</u>			
22. I hereby certify that I attended the deceased from <u>11/19/55</u> , 19 <u>55</u> , to <u>11/21/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/21/55</u> , 19 <u>55</u> , and that death occurred at <u>1205 Ave</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. W. W. W.</u>				ADDRESS (Street, city, town, state) <u>Friendship aa MD</u>		DATE SIGNED <u>11/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>aa MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. W. W. W.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. W. W.</u>		ADDRESS <u>Friendship aa MD</u>	
DATE <u>11/23/55</u>							

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THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE A MEDICAL JUDGMENT OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL TRANSMIT IT TO THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL TRANSMIT IT TO THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

1915 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10412

Reg. Dist. No.

1. NAME OF DECEASED (Print Name)

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. CAUSE OF DEATH

12. MANNER OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF BUREAU

16. SIGNATURE OF DEPARTMENT

17. SIGNATURE OF STATE

18. SIGNATURE OF NATION

19. SIGNATURE OF WORLD

20. SIGNATURE OF UNIVERSE

21. SIGNATURE OF GOD

22. SIGNATURE OF HEAVEN

23. SIGNATURE OF EARTH

24. SIGNATURE OF WATER

25. SIGNATURE OF FIRE

26. SIGNATURE OF AIR

27. SIGNATURE OF LIGHT

28. SIGNATURE OF DARKNESS

29. SIGNATURE OF LIFE

30. SIGNATURE OF DEATH

31. SIGNATURE OF REBIRTH

32. SIGNATURE OF RESURRECTION

33. SIGNATURE OF JUDGMENT

34. SIGNATURE OF GLORY

35. SIGNATURE OF HONOR

36. SIGNATURE OF POWER

37. SIGNATURE OF WEALTH

38. SIGNATURE OF POVERTY

39. SIGNATURE OF KNOWLEDGE

40. SIGNATURE OF IGNORANCE

41. SIGNATURE OF TRUTH

42. SIGNATURE OF LIE

43. SIGNATURE OF GOOD

44. SIGNATURE OF EVIL

45. SIGNATURE OF JUSTICE

46. SIGNATURE OF INJUSTICE

47. SIGNATURE OF MERCY

48. SIGNATURE OF CLEMENCY

49. SIGNATURE OF GRACE

50. SIGNATURE OF FAVOR

51. SIGNATURE OF PITY

52. SIGNATURE OF COMPASSION

53. SIGNATURE OF KINDNESS

54. SIGNATURE OF GENTLENESS

55. SIGNATURE OF MEANNESS

56. SIGNATURE OF CRUELTY

57. SIGNATURE OF RUTHLESSNESS

58. SIGNATURE OF BARBARISM

59. SIGNATURE OF SAVAGERY

60. SIGNATURE OF VIOLENCE

61. SIGNATURE OF WAR

62. SIGNATURE OF PEACE

63. SIGNATURE OF ORDER

64. SIGNATURE OF DISORDER

65. SIGNATURE OF CLEANLINESS

66. SIGNATURE OF DIRTINESS

67. SIGNATURE OF BEAUTY

68. SIGNATURE OF UGLINESS

69. SIGNATURE OF HEALTH

70. SIGNATURE OF DISEASE

71. SIGNATURE OF STRENGTH

72. SIGNATURE OF WEAKNESS

73. SIGNATURE OF VIGOR

74. SIGNATURE OF LETHARGY

75. SIGNATURE OF ENERGY

76. SIGNATURE OF INERTIA

77. SIGNATURE OF ACTION

78. SIGNATURE OF INACTION

79. SIGNATURE OF MOTION

80. SIGNATURE OF STATION

81. SIGNATURE OF CHANGE

82. SIGNATURE OF NO CHANGE

83. SIGNATURE OF IMPROVEMENT

84. SIGNATURE OF DEGRADATION

85. SIGNATURE OF PROGRESS

86. SIGNATURE OF REGRESSION

87. SIGNATURE OF DEVELOPMENT

88. SIGNATURE OF RETROGRESSION

89. SIGNATURE OF PERFECTION

90. SIGNATURE OF IMPERFECTION

91. SIGNATURE OF COMPLETION

92. SIGNATURE OF INCOMPLETION

93. SIGNATURE OF SUCCESS

94. SIGNATURE OF FAILURE

95. SIGNATURE OF TRIUMPH

96. SIGNATURE OF DEFEAT

97. SIGNATURE OF VICTORY

98. SIGNATURE OF DEFECTION

99. SIGNATURE OF ADHESION

100. SIGNATURE OF SECESSION

101. SIGNATURE OF UNION

102. SIGNATURE OF DISUNION

103. SIGNATURE OF COOPERATION

104. SIGNATURE OF NON-COOPERATION

105. SIGNATURE OF ASSISTANCE

106. SIGNATURE OF OBSTACLE

107. SIGNATURE OF FACILITATION

108. SIGNATURE OF HINDERANCE

109. SIGNATURE OF PROMOTION

110. SIGNATURE OF DEPRESSION

111. SIGNATURE OF ELEVATION

112. SIGNATURE OF DEPRESSION

113. SIGNATURE OF EXALTATION

114. SIGNATURE OF HUMILIATION

115. SIGNATURE OF GLORIFICATION

116. SIGNATURE OF CONDEMNATION

117. SIGNATURE OF JUSTIFICATION

118. SIGNATURE OF DOOM

119. SIGNATURE OF SALVATION

120. SIGNATURE OF DESTRUCTION

121. SIGNATURE OF PRESERVATION

122. SIGNATURE OF CONSUMPTION

123. SIGNATURE OF PRESERVATION

124. SIGNATURE OF DESTRUCTION

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10426 CERTIFICATE OF DEATH

10416

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>71 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1711 W. Mosher Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Alexander Johnson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 10 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 15, 1887</u>	9. AGE last birthday <u>68?</u> yrs.	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Hypostatic Pneumonia, Cardiac Decompensation, Auricular Fibrillation, Cerebral Arteriosclerosis</u>							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>8/21</u> , 19 <u>55</u> , to <u>11/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/10</u> , 19 <u>55</u> , and that death occurred at <u>10:20 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Kilday Heard Rinsma</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>11/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>mt auburn</u>		LOCATION (City, town, or county) (State) <u>and</u>	
24. REC'D BY REGISTRAR <u>Nov. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>J. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George S. Nelson</u>		ADDRESS <u>1348 N. Calhoun St</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10392

CERTIFICATE OF DEATH

10419

Reg. Dist. No. 21

1. PLACE OF DEATH ANNE ARUNDEL COUNTY MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY ANNE ARUNDEL			
CITY (If outside corporate limits, write RURAL OR and give nearest town) 10 TOWN ANNAPOLIS		LENGTH OF STAY (in this place) 63 HRS HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNE ARUNDEL GEN'L.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN ANNAPOLIS 10		STREET ADDRESS (If rural give location) 31 MURRAY AV. 1	
3. NAME OF DECEASED (Type or Print) (First) ANNIE (Middle) KATZIN (Last) KATZIN				4. DATE OF DEATH (Month) NOV. (Day) 29 (Year) 19 55			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH 12-24-1888	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Our home		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard S. Cohen				14. MOTHER'S MAIDEN NAME Helen Hae			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT & ADDRESS S. MILTON KATZIN 155 MONTICELLO AVE ANNAPOLIS, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) CEREBROVASCULAR ACCIDENT						5 DAYS	
ANTECEDENT CAUSE(S) DUE TO (B) MYOCARDIAL INFARCTION						7 DAYS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) GENERALIZED ARTERIOSCLEROSIS						20 YRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DIABETES MELLITUS						20 YRS	
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from NOV 22, 19 53, to NOV 29, 19 55, that I last saw the deceased alive on NOV 28, 19 55, and that death occurred at 9:49 A.M. from the causes and on the date stated above. 11/29/55							
SIGNATURE John H. Hatzdeman				ADDRESS (Street, city, town, state) DATE SIGNED M.D. 90 Cathedral St., Annapolis, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11-30-55		NAME OF CEMETERY OR CREMATORY KNESETH ISRAEL		LOCATION (City, town, or county) (State) ANNAPOLIS, MD	
24. REC'D BY REGISTRAR DATE 11-30-55		REGISTRAR'S SIGNATURE J. O. Daniel		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOPPING FUNERAL HOME ANNAPOLIS, MD.			

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THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT SHOULD BE FILLED OUT AS SOON AS POSSIBLE AFTER DEATH, AND BEFORE THE BODY IS BURIED OR CREMATED. IT SHOULD BE FILLED OUT IN THE PRESENCE OF TWO OTHER PERSONS, ONE OF WHOM SHOULD BE A MEMBER OF THE FAMILY. IT SHOULD BE FILLED OUT IN THE PRESENCE OF TWO OTHER PERSONS, ONE OF WHOM SHOULD BE A MEMBER OF THE FAMILY. IT SHOULD BE FILLED OUT IN THE PRESENCE OF TWO OTHER PERSONS, ONE OF WHOM SHOULD BE A MEMBER OF THE FAMILY.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

10412

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED		15. SIGNATURE OF DECEASED	
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MARYLAND STATE DEPARTMENT OF HEALTH
10427 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10420

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Phelps Ave. Gerard Plaza</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> STREET ADDRESS (If rural, give location) <u>205 Harford Rd. Glen Garden</u>	
3. NAME OF DECEASED (Type or Print) <u>Albert Kent Lancaster</u>	(First) <u>Albert</u> (Middle) <u>Kent</u> (Last) <u>Lancaster</u>	4. DATE OF DEATH <u>Nov. 29 1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/14/93</u>
9. AGE last birthday <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Floyd County, Virginia.</u>	11. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
12. FATHER'S NAME <u>Garland Lancaster</u>		13. MOTHER'S MAIDEN NAME <u>Salley Harrell</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>0</u>		15. SOCIAL SECURITY No. <u>236-09-6451</u>	
16. INFORMANT <u>Mr. Harold Lancaster (Son)</u>		17. <u>Glen Burnie, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		<u>Sudden</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>Custome N. Pauchaud</u> Deputy Medical Examiner		DATE SIGNED <u>11/29/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Dec. 4, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>
LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>	(State) <u>Maryland</u>	24. FUNERAL DIRECTOR <u>R. Singleton</u>
DATE REC'D BY LOCAL REG. <u>Dec 1 1955</u>	REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	ADDRESS <u>Glen Burnie, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10421

10393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>APPO</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>A.A.C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Annapolis, Md.</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Anne Arundel Gen'l. Hosp.		STREET ADDRESS (If rural give location)		Quarters U.S. Experimental Sta! <u>Franklin Street</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>MARtha</u> (Middle) <u>M.</u> (Last) <u>LANGE</u>				November 29, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE MARRIED WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
7	W	single married widowed divorced	NOV 2, 1900	85 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife		at home		Holland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Leonard Meyers				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		no		Annapolis, Md. Mr. Leonard P. Lange-U.S. NEES Qtr. I			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
570.5 IMMEDIATE CAUSE (A) <u>intestinal obstruction</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>previous abdominal surgery 1945</u>						12 hrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerosis cardiovascular disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1, 1954</u> to <u>Nov 29, 1955</u> that I last saw the deceased alive on <u>11-29-55</u> and that death occurred at <u>12:45</u> M. from the causes and on the date stated above. SIGNATURE <u>South Reader</u> M.D. <u>45 Franklin St Annapolis Md</u> DATE SIGNED 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>12/1/55</u> NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u> LOCATION (City, town, or county) <u>Lorraine, Md.</u> (State) 24. REC'D BY REGISTRAR <u>Thm. J. French</u> REGISTRAR'S SIGNATURE <u>Thm. J. French</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>Thm. J. French & Louis Roed</u> ADDRESS <u>17</u>							

NOV 30 1955

10888 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

REG. DIST. NO.

1. DECEASED'S NAME (Last, first, middle)

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. US. CITIZENSHIP

9. PRESENT RESIDENCE

10. DATE OF DEATH

11. PLACE OF DEATH

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF BURIAL PLACE

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF CLERK

25. SIGNATURE OF RECORDER

26. SIGNATURE OF ARCHIVER

BUREAU V. S.

DEC 1 1955

RECEIVED

RECEIVED

1. DECEASED'S NAME (Last, first, middle)
2. SEX
3. RACE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. US. CITIZENSHIP
9. PRESENT RESIDENCE
10. DATE OF DEATH
11. PLACE OF DEATH
12. CAUSE OF DEATH
13. MANNER OF DEATH
14. SIGNATURE OF PHYSICIAN
15. SIGNATURE OF REGISTRAR
16. SIGNATURE OF WITNESSES
17. SIGNATURE OF DECEASED
18. SIGNATURE OF FUNERAL HOME
19. SIGNATURE OF BURIAL PLACE
20. SIGNATURE OF INTERVIEWER
21. SIGNATURE OF CORONER
22. SIGNATURE OF JURY
23. SIGNATURE OF JUDGE
24. SIGNATURE OF CLERK
25. SIGNATURE OF RECORDER
26. SIGNATURE OF ARCHIVER

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10428 CERTIFICATE OF DEATH

10422

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A</u> <u>A</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>LINTHICUM</u>		<u>30 yrs</u>		TOWN <u>LINTHICUM</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 Sycamore Rd.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph Burton Lewis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 1 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>DEC 3 1862</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>West River, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis Duval Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Emily Carrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Helen Lewis 108 Sycamore Rd. Durham Linticum Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardio-vascular Disease</u>						<u>5 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u> M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1950</u> , to <u>Nov 1, 1955</u> , that I last saw the deceased alive on <u>Oct 31, 1955</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James S. Bullenberger</u> M.D.				ADDRESS (Street, city, town, state) <u>108 Central Ave. Glen Burnie Md.</u>			
DATE SIGNED <u>Nov 2, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 5 1955</u>		NAME OF CEMETERY OR CREMATORY <u>2nd Cr.</u>		LOCATION (City, town, or county) (State) <u>Walesville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Caldwell Woodruff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Walesville Md.</u>	
DATE <u>Nov 9, 1955</u>							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10394

CERTIFICATE OF DEATH

10423

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Annapolis MD</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Annapolis</u>		CITY OR TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPA ROAD</u>		STREET ADDRESS <u>SPA R.D.</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Marquerite Gwendoline Linthicum</u>				<u>Nov. 27</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F.</u>	<u>W.</u>	<u>SINGLE</u>	<u>15 Aug 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Teacher</u>		<u>SCHOOL</u>		<u>Annapolis MD, U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Theodore H. Linthicum</u>				<u>Mitchell L. George Ann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
204.0 IMMEDIATE CAUSE (A) <u>① Lymphatic Leukemia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Nov 1955</u> to <u>27 Nov 1955</u>, that I last saw the deceased alive on <u>26 Nov 1955</u>, and that death occurred at <u>12:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>A. Halpin</u>		<u>Severna Park</u>		<u>27 Nov 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-28-55</u>		<u>Cedar Bluff</u>		<u>Annapolis Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov. 28, 1955</u>		<u>J. O. Daniel</u>		<u>John M. Taylor Sons</u>		<u>Annapolis Md</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10395

CERTIFICATE OF DEATH

10424

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A. Co.</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A. A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 11 1/2 College Ave.</u>				STREET ADDRESS (If rural give location) <u>11 1/2 College Ave.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>EUSTACE MATTHEWS</u>				<u>11 17 19 55</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>COL</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>		8. DATE OF BIRTH <u>6-27-1887</u>	
				9. AGE last birthday <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEWIS MATTHEWS</u>				14. MOTHER'S MAIDEN NAME <u>SUSIE GROSS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>211-03-0314</u>		17. INFORMANT & ADDRESS <u>MARGARET MATTHEWS-ANNA Md</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) Coronary Occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-29-55</u> to <u>11-17-55</u>, that I last saw the deceased alive on <u>10-29-55</u>, and that death occurred at <u>12 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Ans. T. Allen</u>				DATE SIGNED <u>11-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>11-20-55</u>			
24. REC'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE			
REGISTRAR'S SIGNATURE <u>Wm. J. French</u>				ADDRESS (Street, city, town, state) <u>WILLIAM REESE, 1108 WASH. ST ANNAPOLIS, MD</u>			
DATE <u>NOV 21 1955</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10429 CERTIFICATE OF DEATH

10425

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Crownsville		7 mos. 16 days		TOWN Baltimore City		3V01.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10 Crownsville State Hospital				2235 Penrose Avenue			
3. NAME OF DECEASED (Type or Print)		(First) Robert		(Middle) McDaniel		(Last)	
				4. DATE OF DEATH		11 20 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	Negro	Married	5-7-03	52 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Pantryman		--		Maryland		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Georgiana McDaniels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes		1923		Unknown			
				Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
023X IMMEDIATE CAUSE (A) Heart Failure						Known to us for	
ANTECEDENT CAUSE(S) DUE TO						7 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) Chronic Brain Syndrome due to CNS Les						Known to us for	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						7 months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
0 --		--					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White Not while at work		21f. HOW DID INJURY OCCUR?			
-- -- -- M.		at work at work		-- -- --			
22. I hereby certify that I attended the deceased from 7/5, 19 55, to 11/20, 19 55, that I last saw the deceased alive on 11/20, 19 55, and that death occurred at 4:45 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Cherett W. Cadenhead</i> M.D.				Crownsville, Md.		11/21/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		11/25/55		Arbutus Cemetery		Baltimore Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
NOV 21 1955		<i>Katherine M. Joyce</i>		<i>Rev. B. B. Brown</i>		1348 N. Calhoun St	

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10430

CERTIFICATE OF DEATH

10426

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Greenway</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Same</u> COUNTY <u>Same</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> TOWN <u>Same</u> STREET ADDRESS (If rural give location) <u>Same</u>			
3. NAME OF DECEASED (Type or Print) <u>Georges John Miedel</u> (First) (Middle) (Last) <u>SR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 10</u> <u>1955</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8/10/81</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wheeling, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Miedel</u>				14. MOTHER'S MAIDEN NAME <u>Magdalen Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>210-01-5356</u>		17. INFORMANT & ADDRESS <u>Mrs. G.J. Miedel (Wife).</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				Sudden			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Cardio vascular diseases</u> (C)				4 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 11/10/55</u> , to <u>11/10/55</u> , 19....., that I last saw the deceased alive on <u>11/10/55</u> , 19....., and that death occurred at <u>1 P.M.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Custom Paubers</u>		M.D. <u>Glen Burnie, Md.</u>		DATE SIGNED <u>11/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>buried</u>		DATE THEREOF <u>Nov 14 55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>		LOCATION (City, town, or county) <u>Worley, Bldd Ind</u> (State)	
24. REC'D BY REGISTRAR DATE <u>Nov 16, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. DeWitt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A. Fink</u> ADDRESS <u>Glen Burnie Md.</u>			

BUREAU V. S.

535T 12 AON

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10431

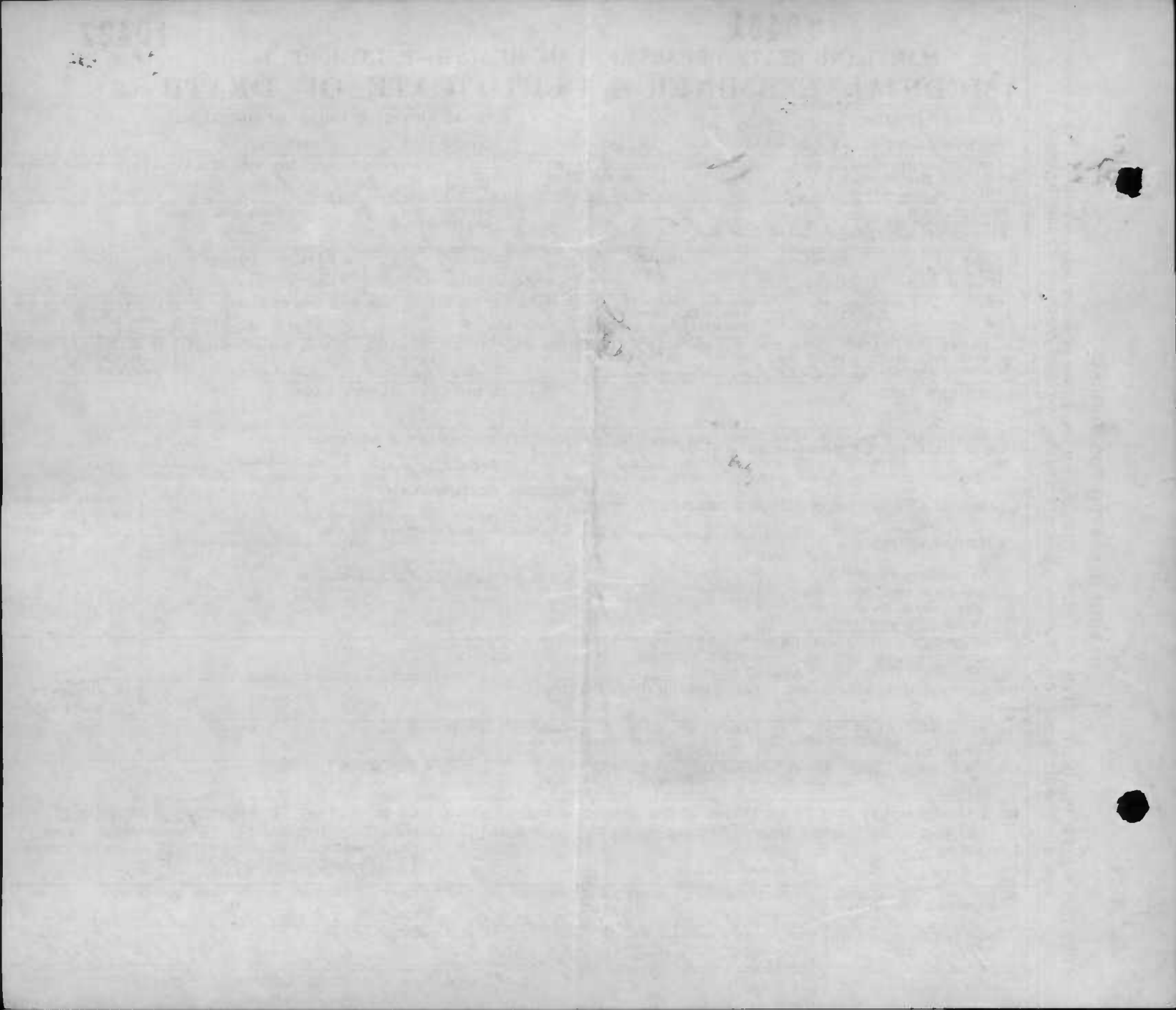
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10427

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Lovett</u>		LENGTH OF STAY (in this place) <u>4 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>New Court Road</u>				STREET ADDRESS (If rural, give location) <u>Same</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Emmett</u> (Last) <u>Emmett</u>				4. DATE OF DEATH (Month) <u>Nov. 11</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1/12/26</u>	9. AGE last birthday: <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u>29</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired bar attendant</u>			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Holland, Europe</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>No</u>		17. INFORMANT & ADDRESS: <u>Miss Ida Crouse, 1400 E. Rd., Laurel, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) <u>General arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						<u>Sudden</u> <u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE <u>Augustine H. Paulsen, M.D.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 14, 1955</u>		<u>Louisa Park</u>		<u>Balto, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>11/14/55</u>		<u>A. W. Hedrick</u>		<u>Wm. Cook, Inc., Balto., Md.</u> <u>Rev. Durward L. Ewingston</u>			



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10396 **CERTIFICATE OF DEATH**

10428

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 ANNE ARUNDEL GEN'L</u>				STREET ADDRESS (If rural give location) <u>15 STATE CIRCLE</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HELEN</u> <u>MITTLE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 27</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>December 29, 1874</u>		9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Proprietor Beauty Shop</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Higgins</u>				14. MOTHER'S MAIDEN NAME <u>Susian Muban</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Y</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Mr Thomas O. Tilghman</u> <u>44 State Circle</u> <u>Annapolis, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u> IMMEDIATE CAUSE (A) <u>CEREBROVASCULAR ACCIDENT</u>						<u>7 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>20 YRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/26</u> , 19 <u>55</u> , to <u>11/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>55</u> , and that death occurred at <u>1:07</u> P.M. from the causes and on the date stated above. <u>11/27/55</u>							
SIGNATURE <u>John H. Hsdeman</u>				DATE SIGNED <u>90 Cathedral St., Annapolis, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Anne's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>11-28-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME ANNA POLIS, MD</u>			

THIS IS THE OFFICIAL RECORD OF THE DEATH OF THE ABOVE NAMED PERSON, AND IT IS THE DUTY OF THE OFFICIALS OF THE HEALTH DEPARTMENT TO RECORD THE DEATH OF EVERY PERSON WHO DIES IN THE CITY OF BALTIMORE, AND TO ISSUE THIS CERTIFICATE OF DEATH TO THE NEXT OF KIN OR TO THE PERSON WHOSE NAME IS ON THE DEED OF BURIAL.

1928 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1928

DATE OF DEATH

1. PLACE OF DEATH

RESIDENCE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

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BUREAU V. S.

NOV 29 1928

RECEIVED

[Handwritten signature]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10432 CERTIFICATE OF DEATH

10429

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural</u> <u>Mayo, Md.</u>		<u>15 years</u>		TOWN <u>Rural</u> <u>Mayo, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Julius Wilmer Morris</u>				<u>Nov. 15 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>		<u>Aug. 13, 1888</u>	<u>67</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Sea Food Broker</u>		<u>Sea Food</u>		<u>Richmond, Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Julius Caesar Morris</u>				<u>Martha Ann Rudd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>U.S. Navy</u>				<u>William F. Burgess Mayo, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1, 1947</u> , to <u>Nov. 15, 1955</u> , that I last saw the deceased alive on <u>Nov. 14, 1955</u> , and that death occurred at <u>5.30P</u> M., from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Francis Goued</u>		<u>11/18/55</u>		<u>Fort Lincoln Crematory</u>		<u>Prince Georges Co., Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Cremation</u>		<u>NOV 17 1955</u>		<u>Edward Collinson</u>		<u>The S. N. Wines Co. 2901 14th St. N.W. Washington 9, D.C.</u>	

10293

CERTIFICATE OF DEATH

THE STATE OF MARYLAND

DEPARTMENT OF HEALTH

NAME OF DECEASED: **John Henry Jones**
 SEX: **Male**
 AGE: **65**
 DATE OF BIRTH: **Nov. 15, 1889**

PLACE OF BIRTH: **St. Louis, Mo.**
 OCCUPATION: **Retired**
 MARITAL STATUS: **Married**

DATE OF DEATH: **Nov. 15, 1955**
 PLACE OF DEATH: **Home**
 CAUSE OF DEATH: **Heart Disease**
 MEDICAL HISTORY: **None**

NAME OF PHYSICIAN: **Dr. J. H. Smith**
 NAME OF HOSPITAL: **None**
 NAME OF NURSE: **None**

NAME OF CORONER: **John A. Brown**
 NAME OF JURY: **None**
 NAME OF JUDGE: **None**

NAME OF BURIAL PLACE: **None**
 NAME OF FUNERAL HOME: **None**
 NAME OF MINISTER: **None**

NAME OF REGISTRAR: **None**
 NAME OF CLERK: **None**
 NAME OF ASSISTANT: **None**

NAME OF WITNESS: **None**
 NAME OF JURY: **None**
 NAME OF JUDGE: **None**

NAME OF REGISTRAR: **None**
 NAME OF CLERK: **None**
 NAME OF ASSISTANT: **None**

BUREAU V. 2

NOV 17 1955

RECEIVED

NOTIFICATION

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy of it is to be sent to the office of the Registrar of the Department of Health, Washington, D.C., and to the office of the Registrar of the Department of Health, St. Louis, Missouri.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

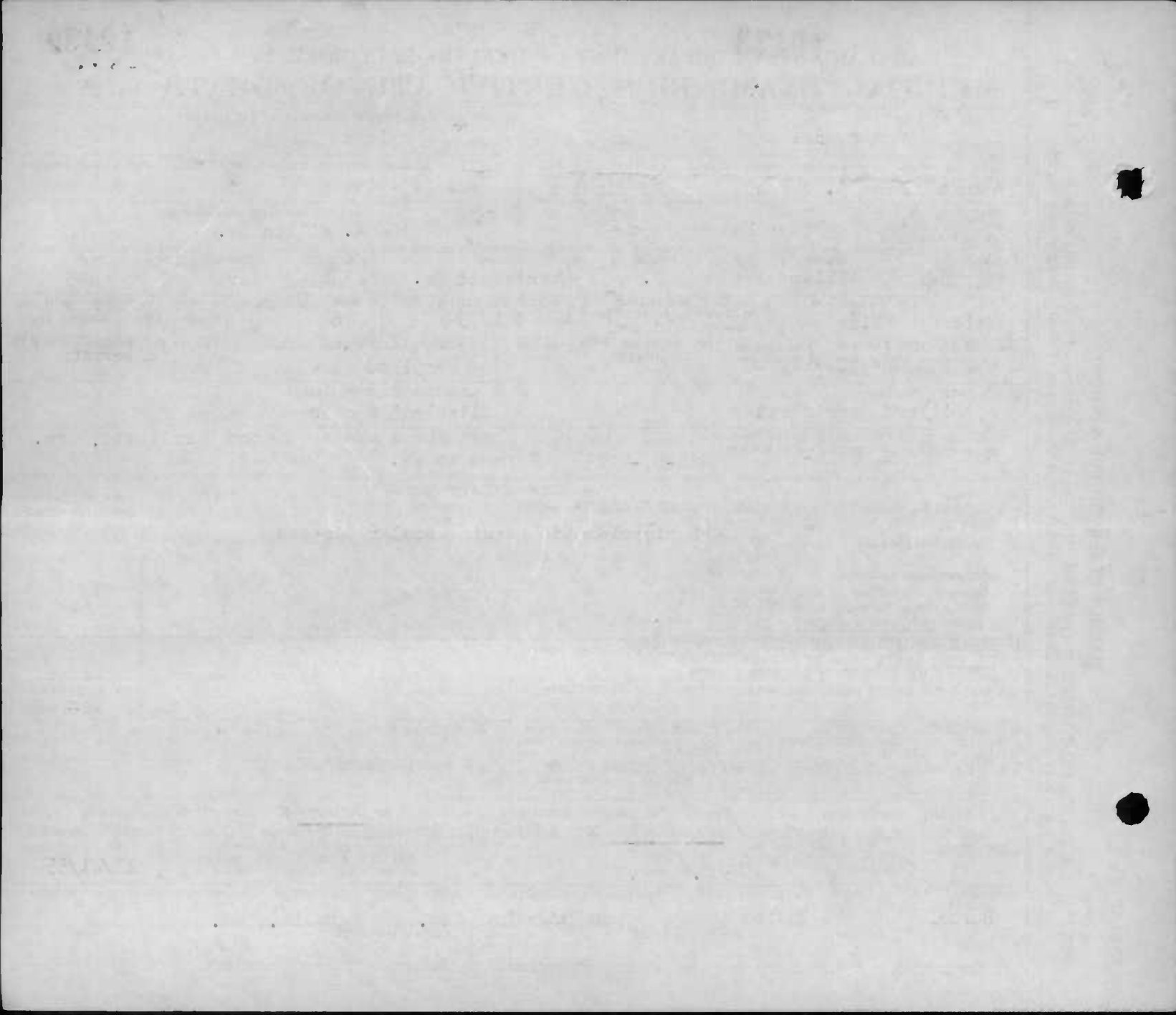
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10430
Reg. Dist. No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Ft George G. Meade</u>		LENGTH OF STAY (in this place) <u>30 minutes</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bldg: NSA Project</u>				STREET ADDRESS (If rural, give location) <u>156 S. Hilton St.</u>			
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>J.</u> (Last) <u>Morrissett Sr.</u>				4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Mar 3 1879</u>	9. AGE last birthday: <u>76</u> yrs.		IF UNDER 1 YEAR (Month) <u>1</u> (Day) <u>15</u> IF UNDER 24 HRS. (Hours) <u>15</u> (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Steamfitter</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Willard Morrissett</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Decker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>3rd</u> (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No.: <u>216-07-8215</u>		17. INFORMANT & ADDRESS: <u>Norton Morrissett, Son.</u> <u>same as #2.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>422.1</u> Immediate cause (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>						19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/21/55</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG. <u>11-22-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
10397 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10431

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Ad.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
TOWN <u>Annapolis</u>		TOWN <u>Annapolis, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>45 Solomons Island Rd.</u>		STREET ADDRESS (If rural, give location) <u>45 Solomons Island Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Arthur</u>		4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>10-15-55</u>	
9. AGE last birthday yrs. <u>1</u> mos. <u>3</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZENSHIP <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur C. Naylor, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Orla Blake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-170</u>	
17. INFORMANT AND ADDRESS <u>Arthur Naylor, Sr. - Annapolis, Md.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
762.0 Immediate cause (a) <u>Aspiration Vomitus</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION <u>0</u>		
19b. MAJOR FINDINGS OF OPERATION		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11-19-55</u> m. <u>11</u>		HOW DID INJURY OCCUR? <u>While at work</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>Chas. Smith</u>		ADDRESS <u>415</u>		DATE SIGNED <u>11-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	
LOCATION (City, town, or county) <u>Annapolis, Md.</u>		DATE REC'D BY LOCAL REG. <u>Nov. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. French</u>	
24. FUNERAL DIRECTOR <u>William Reese, Jr.</u>		ADDRESS <u>108 Nash St.</u>		<u>Annapolis, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

NOV 24 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
10434 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10432

Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pasadena				CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 26			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vll Avenue, Green Haven				STREET ADDRESS (If rural, give location) 3919 Pascal Street			
3. NAME OF DECEASED (Type or Print) Bailey Paul Nicholson		(First) (Middle) (Last)		4. DATE OF DEATH Nov. 4th. 1955		(Month) (Day) (Year)	
5. SEX M.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1/28/98	9. AGE last birthday 57 yrs.	If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Catherine Myers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY No. W.W. #1		17. INFORMANT Mrs. Jean Nicholson, (wife).	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Coronary Occlusion Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)						Sudden	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE Gustav P. Paubert				Deputy Medical Examiner Glen Burnie, Md.		DATE SIGNED 11/4/55	
23. BURIAL, CREMATION REMOVAL (Specify) B		DATE THEREOF 11/8/55		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore	
DATE REC'D BY LOCAL REG. 11-7-55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR McCully Funeral Homes - 130 E. Fort Ave.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12.1.19

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10433

10435 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Same</u>		COUNTY <u>Same</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>P.O. Glen Burnie</u>		<u>Life</u>		TOWN <u>Same</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29 Cedar Drive Marley Park</u>				STREET ADDRESS <u>Same</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sherry Lynn</u> (Middle) <u>Osborne</u> (Last)				(Month) <u>11/8/55</u> (Day) <u>19</u> (Year)			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S.</u>	8. DATE OF BIRTH <u>11/8/55</u>	9. AGE last birthday <u>19</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Marley Park, Glen Burnie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Osborne</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. H. Osborne, (mother)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>776X Premature</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/8/55</u> , 19....., to <u>11/8/55</u> , 19....., that I last saw the deceased alive on <u>11/8/55</u> , 19....., and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gustave J. Pauchard</u>				ADDRESS (Street, city, town, state) <u>M. D. Glen Burnie, Md.</u>		DATE SIGNED <u>11/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>11/9/55</u>	NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>"Nov 9, 1955"</u>	REGISTRAR'S SIGNATURE <u>L. J. D'Alba</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Purkley</u>		ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10436 **CERTIFICATE OF DEATH**

10434

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md.</u>		COUNTY <u>A. Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS <u>RFD 5</u>		Box <u>275</u>			
3. NAME OF DECEASED (Type or Print) <u>EMMA</u> (First) <u>PACK</u> (Last)				4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Rhoda Baker Pasadena Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>491X</u> <u>Bronchopneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>old age</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 13</u> , 19 <u>55</u> , to <u>Nov 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 13</u> , 19 <u>55</u> , and that death occurred at <u>8:20</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Joseph Tater</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>Nov 14, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>11/17/1955</u>		NAME OF CEMETERY OR CREMATORY <u>AM ZION CHURCH</u>	
24. REC'D BY REGISTRAR <u>NOV 15 1955</u>				REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hayes</u>	
				ADDRESS		<u>Balto. Md.</u>	

10534

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

10534 CERTIFICATE OF DEATH

Reg. Dist. No.

A. DEATH INFORMATION (DATE OF DEATH)

B. PLACE OF DEATH

C. DEATH INFORMATION (NAME OF DECEASED)

D. DEATH INFORMATION (DATE OF DEATH)

E. DEATH INFORMATION (DATE OF DEATH)

F. DEATH INFORMATION (DATE OF DEATH)

G. DEATH INFORMATION (DATE OF DEATH)

H. DEATH INFORMATION (DATE OF DEATH)

I. DEATH INFORMATION (DATE OF DEATH)

J. DEATH INFORMATION (DATE OF DEATH)

K. DEATH INFORMATION (DATE OF DEATH)

L. DEATH INFORMATION (DATE OF DEATH)

M. DEATH INFORMATION (DATE OF DEATH)

N. DEATH INFORMATION (DATE OF DEATH)

O. DEATH INFORMATION (DATE OF DEATH)

P. DEATH INFORMATION (DATE OF DEATH)

Q. DEATH INFORMATION (DATE OF DEATH)

R. DEATH INFORMATION (DATE OF DEATH)

S. DEATH INFORMATION (DATE OF DEATH)

T. DEATH INFORMATION (DATE OF DEATH)

U. DEATH INFORMATION (DATE OF DEATH)

V. DEATH INFORMATION (DATE OF DEATH)

W. DEATH INFORMATION (DATE OF DEATH)

X. DEATH INFORMATION (DATE OF DEATH)

Y. DEATH INFORMATION (DATE OF DEATH)

Z. DEATH INFORMATION (DATE OF DEATH)

AA. DEATH INFORMATION (DATE OF DEATH)

AB. DEATH INFORMATION (DATE OF DEATH)

AC. DEATH INFORMATION (DATE OF DEATH)

AD. DEATH INFORMATION (DATE OF DEATH)

AE. DEATH INFORMATION (DATE OF DEATH)

AF. DEATH INFORMATION (DATE OF DEATH)

AG. DEATH INFORMATION (DATE OF DEATH)

AH. DEATH INFORMATION (DATE OF DEATH)

AI. DEATH INFORMATION (DATE OF DEATH)

AJ. DEATH INFORMATION (DATE OF DEATH)

AK. DEATH INFORMATION (DATE OF DEATH)

AL. DEATH INFORMATION (DATE OF DEATH)

AM. DEATH INFORMATION (DATE OF DEATH)

AN. DEATH INFORMATION (DATE OF DEATH)

AO. DEATH INFORMATION (DATE OF DEATH)

AP. DEATH INFORMATION (DATE OF DEATH)

AQ. DEATH INFORMATION (DATE OF DEATH)

AR. DEATH INFORMATION (DATE OF DEATH)

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. RELIGION

10. RACE

11. SOCIAL SECURITY NUMBER

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF DEATH

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. SIGNATURE OF DECEASED

18. SIGNATURE OF WITNESS

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF JUDGE

23. SIGNATURE OF CLERK

24. SIGNATURE OF NOTARY

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF DEPUTY SHERIFF

27. SIGNATURE OF CONSTABLE

28. SIGNATURE OF JAILER

29. SIGNATURE OF PRISONER

30. SIGNATURE OF GUARD

31. SIGNATURE OF WARDEN

32. SIGNATURE OF CHANCELLER

33. SIGNATURE OF CLERK OF COURT

34. SIGNATURE OF JURY

35. SIGNATURE OF JUDGE

36. SIGNATURE OF CLERK

37. SIGNATURE OF NOTARY

38. SIGNATURE OF SHERIFF

39. SIGNATURE OF DEPUTY SHERIFF

40. SIGNATURE OF CONSTABLE

41. SIGNATURE OF JAILER

42. SIGNATURE OF PRISONER

43. SIGNATURE OF GUARD

44. SIGNATURE OF WARDEN

45. SIGNATURE OF CHANCELLER

46. SIGNATURE OF CLERK OF COURT

47. SIGNATURE OF JURY

48. SIGNATURE OF JUDGE

49. SIGNATURE OF CLERK

50. SIGNATURE OF NOTARY

51. SIGNATURE OF SHERIFF

52. SIGNATURE OF DEPUTY SHERIFF

53. SIGNATURE OF CONSTABLE

54. SIGNATURE OF JAILER

55. SIGNATURE OF PRISONER

56. SIGNATURE OF GUARD

57. SIGNATURE OF WARDEN

58. SIGNATURE OF CHANCELLER

59. SIGNATURE OF CLERK OF COURT

60. SIGNATURE OF JURY

61. SIGNATURE OF JUDGE

62. SIGNATURE OF CLERK

63. SIGNATURE OF NOTARY

64. SIGNATURE OF SHERIFF

65. SIGNATURE OF DEPUTY SHERIFF

66. SIGNATURE OF CONSTABLE

67. SIGNATURE OF JAILER

68. SIGNATURE OF PRISONER

69. SIGNATURE OF GUARD

70. SIGNATURE OF WARDEN

71. SIGNATURE OF CHANCELLER

72. SIGNATURE OF CLERK OF COURT

73. SIGNATURE OF JURY

74. SIGNATURE OF JUDGE

75. SIGNATURE OF CLERK

76. SIGNATURE OF NOTARY

77. SIGNATURE OF SHERIFF

78. SIGNATURE OF DEPUTY SHERIFF

79. SIGNATURE OF CONSTABLE

80. SIGNATURE OF JAILER

81. SIGNATURE OF PRISONER

82. SIGNATURE OF GUARD

83. SIGNATURE OF WARDEN

84. SIGNATURE OF CHANCELLER

85. SIGNATURE OF CLERK OF COURT

86. SIGNATURE OF JURY

87. SIGNATURE OF JUDGE

88. SIGNATURE OF CLERK

89. SIGNATURE OF NOTARY

90. SIGNATURE OF SHERIFF

91. SIGNATURE OF DEPUTY SHERIFF

92. SIGNATURE OF CONSTABLE

93. SIGNATURE OF JAILER

94. SIGNATURE OF PRISONER

95. SIGNATURE OF GUARD

96. SIGNATURE OF WARDEN

97. SIGNATURE OF CHANCELLER

98. SIGNATURE OF CLERK OF COURT

99. SIGNATURE OF JURY

100. SIGNATURE OF JUDGE

101. SIGNATURE OF CLERK

102. SIGNATURE OF NOTARY

103. SIGNATURE OF SHERIFF

104. SIGNATURE OF DEPUTY SHERIFF

105. SIGNATURE OF CONSTABLE

106. SIGNATURE OF JAILER

107. SIGNATURE OF PRISONER

108. SIGNATURE OF GUARD

109. SIGNATURE OF WARDEN

110. SIGNATURE OF CHANCELLER

111. SIGNATURE OF CLERK OF COURT

112. SIGNATURE OF JURY

113. SIGNATURE OF JUDGE

114. SIGNATURE OF CLERK

115. SIGNATURE OF NOTARY

116. SIGNATURE OF SHERIFF

117. SIGNATURE OF DEPUTY SHERIFF

118. SIGNATURE OF CONSTABLE

119. SIGNATURE OF JAILER

120. SIGNATURE OF PRISONER

121. SIGNATURE OF GUARD

122. SIGNATURE OF WARDEN

123. SIGNATURE OF CHANCELLER

124. SIGNATURE OF CLERK OF COURT

125. SIGNATURE OF JURY

126. SIGNATURE OF JUDGE

127. SIGNATURE OF CLERK

128. SIGNATURE OF NOTARY

129. SIGNATURE OF SHERIFF

130. SIGNATURE OF DEPUTY SHERIFF

131. SIGNATURE OF CONSTABLE

132. SIGNATURE OF JAILER

133. SIGNATURE OF PRISONER

134. SIGNATURE OF GUARD

135. SIGNATURE OF WARDEN

136. SIGNATURE OF CHANCELLER

137. SIGNATURE OF CLERK OF COURT

138. SIGNATURE OF JURY

139. SIGNATURE OF JUDGE

140. SIGNATURE OF CLERK

141. SIGNATURE OF NOTARY

142. SIGNATURE OF SHERIFF

143. SIGNATURE OF DEPUTY SHERIFF

144. SIGNATURE OF CONSTABLE

145. SIGNATURE OF JAILER

146. SIGNATURE OF PRISONER

147. SIGNATURE OF GUARD

148. SIGNATURE OF WARDEN

149. SIGNATURE OF CHANCELLER

150. SIGNATURE OF CLERK OF COURT

151. SIGNATURE OF JURY

152. SIGNATURE OF JUDGE

153. SIGNATURE OF CLERK

154. SIGNATURE OF NOTARY

155. SIGNATURE OF SHERIFF

156. SIGNATURE OF DEPUTY SHERIFF

157. SIGNATURE OF CONSTABLE

158. SIGNATURE OF JAILER

159. SIGNATURE OF PRISONER

160. SIGNATURE OF GUARD

161. SIGNATURE OF WARDEN

162. SIGNATURE OF CHANCELLER

163. SIGNATURE OF CLERK OF COURT

164. SIGNATURE OF JURY

165. SIGNATURE OF JUDGE

166. SIGNATURE OF CLERK

167. SIGNATURE OF NOTARY

168. SIGNATURE OF SHERIFF

169. SIGNATURE OF DEPUTY SHERIFF

170. SIGNATURE OF CONSTABLE

171. SIGNATURE OF JAILER

172. SIGNATURE OF PRISONER

173. SIGNATURE OF GUARD

174. SIGNATURE OF WARDEN

175. SIGNATURE OF CHANCELLER

176. SIGNATURE OF CLERK OF COURT

177. SIGNATURE OF JURY

178. SIGNATURE OF JUDGE

179. SIGNATURE OF CLERK

180. SIGNATURE OF NOTARY

181. SIGNATURE OF SHERIFF

182. SIGNATURE OF DEPUTY SHERIFF

183. SIGNATURE OF CONSTABLE

184. SIGNATURE OF JAILER

185. SIGNATURE OF PRISONER

186. SIGNATURE OF GUARD

187. SIGNATURE OF WARDEN

188. SIGNATURE OF CHANCELLER

189. SIGNATURE OF CLERK OF COURT

190. SIGNATURE OF JURY

191. SIGNATURE OF JUDGE

192. SIGNATURE OF CLERK

193. SIGNATURE OF NOTARY

194. SIGNATURE OF SHERIFF

195. SIGNATURE OF DEPUTY SHERIFF

196. SIGNATURE OF CONSTABLE

197. SIGNATURE OF JAILER

198. SIGNATURE OF PRISONER

199. SIGNATURE OF GUARD

200. SIGNATURE OF WARDEN

201. SIGNATURE OF CHANCELLER

202. SIGNATURE OF CLERK OF COURT

203. SIGNATURE OF JURY

204. SIGNATURE OF JUDGE

205. SIGNATURE OF CLERK

206. SIGNATURE OF NOTARY

207. SIGNATURE OF SHERIFF

208. SIGNATURE OF DEPUTY SHERIFF

209. SIGNATURE OF CONSTABLE

210. SIGNATURE OF JAILER

211. SIGNATURE OF PRISONER

212. SIGNATURE OF GUARD

213. SIGNATURE OF WARDEN

214. SIGNATURE OF CHANCELLER

215. SIGNATURE OF CLERK OF COURT

216. SIGNATURE OF JURY

217. SIGNATURE OF JUDGE

218. SIGNATURE OF CLERK

219. SIGNATURE OF NOTARY

220. SIGNATURE OF SHERIFF

221. SIGNATURE OF DEPUTY SHERIFF

222. SIGNATURE OF CONSTABLE

223. SIGNATURE OF JAILER

224. SIGNATURE OF PRISONER

225. SIGNATURE OF GUARD

226. SIGNATURE OF WARDEN

227. SIGNATURE OF CHANCELLER

228. SIGNATURE OF CLERK OF COURT

229. SIGNATURE OF JURY

230. SIGNATURE OF JUDGE

231. SIGNATURE OF CLERK

232. SIGNATURE OF NOTARY

233. SIGNATURE OF SHERIFF

234. SIGNATURE OF DEPUTY SHERIFF

235. SIGNATURE OF CONSTABLE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10398 CERTIFICATE OF DEATH

10435

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE Md.		COUNTY C.A.			
CITY (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 18 Clay St.				STREET ADDRESS (If rural give location) 18 Clay St.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Joseph S. Parker				4. DATE OF DEATH (Month) (Day) (Year) 11 19 55			
5. SEX male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH 9-30-1910	9. AGE last birthday 45 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Exp. Station		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James Parker				14. MOTHER'S MAIDEN NAME Georganna Sellman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 597-32-0299		17. INFORMANT'S ADDRESS Marion Parker - Annapolis, Md. 18 Clay St.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A) Cancer of colon & Metastases of liver				INTERVAL BETWEEN ONSET AND DEATH 6 mos +			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION July 1955		19b. MAJOR FINDINGS OF OPERATION Ca. of ascending colon		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from August 1955, to 11/19, 1955, that I last saw the deceased alive on 11/18, 1955, and that death occurred at 6 P.M. from the causes and on the date stated above.							
SIGNATURE Marie K. Klamansky, M.D.				ADDRESS (Street, city, town, state) Annapolis, Md.		DATE SIGNED 11/21/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-23-55		NAME OF CEMETERY OR CREMATORY Adams Chapel		LOCATION (City, town, or county) Bayard, Md.	
24. REC'D BY REGISTRAR DATE NOV 21 1955		REGISTRAR'S SIGNATURE Wm. J. French		25. FUNERAL DIRECTOR'S SIGNATURE William Reese		ADDRESS Annapolis	

CERTIFICATE OF DEATH

Form No. 10

1. FULL NAME OF DECEASED

2. PLACE OF BIRTH

Mr. C. C. [illegible]
[illegible]
18 [illegible] St.

George [illegible]
[illegible]
18 [illegible] St.

3. DATE OF DEATH
Nov 11 1955

4. TIME OF DEATH
[illegible]

5. CAUSE OF DEATH
[illegible]
[illegible]
[illegible]

6. MANNER OF DEATH
[illegible]
[illegible]
[illegible]

7. SIGNATURE OF PHYSICIAN

8. SIGNATURE OF REGISTRAR

BUREAU V. S.

NOV 27 1955

RECEIVED

11-23-55 [illegible]
[illegible]

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10437 CERTIFICATE OF DEATH

10436

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>2 weeks</u>		TOWN <u>Glen Burnie, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>520 Delmar Ave SE</u>				STREET ADDRESS (If rural give location) <u>520 Delmar Ave SE</u>			
3. NAME OF DECEASED (Type or Print) <u>Gene Raymond Pearson, Jr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 25, 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 7, 1955</u>	9. AGE last birthday yrs. <u>18</u>	IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>18</u> Min. <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Gene Raymond Pearson, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Belcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Gene Raymond Pearson, same as 2</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Asphyxiation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-10 MIN.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>MUCUS IN TRACHEA</u>						<u>12 HRS. -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>UPPER RESPIRATORY INFECTION</u>						<u>2 DA.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE -</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-7</u> , 19 <u>55</u> , to <u>11-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-23</u> , 19 <u>55</u> , and that death occurred at <u>7:15A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leon C. Perry</u>				ADDRESS (Street, city, town, state) <u>201 BLA Blvd, GLEN BURNIE, MD.</u>			
DATE <u>Nov 25 1955</u>				DATE SIGNED <u>11-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

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1044 JOURNAL OF POST KEYNESIAN ECONOMICS

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10437

10438 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH- COUNTY Anne Arundel				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Anne Arundel			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort George G. Meade				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Linthicum			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital				STREET ADDRESS (If rural, give location) 407 Forrest View Road			
3. NAME OF DECEASED (Type or Print) Edward		(First)		(Middle) E. C.		(Last) Penney	
4. DATE OF DEATH		(Month) Nov		(Day) 22		(Year) 1955	
5. SEX M M		6. COLOR OR RACE W W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH May 28, 1886	
9. AGE last birthday 69 yrs.		If under 1 year Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1906-1933	
16. SOCIAL SECURITY No		17. INFORMANT AND ADDRESS Mrs. Elizabeth Penney, Linthicum Hts, Md.		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
5020 Immediate cause (a) Cardiac failure				2 days			
Antecedent cause(s) (b) Pulmonary emphysema				2 years			
(c) Chronic-bronchitis, bronchiectasis & obstructive emphysema							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 21, 1955, to Nov 22, 1955, that I last saw the deceased alive on Nov 21, 1955, and that death occurred at 8:45 a.m., from the causes and on the date stated above.							
SIGNATURE SAMUEL D. GARY, MD (Degree or title)				ADDRESS 714 Park Avenue-1			
DATE SIGNED 22 Nov 55							
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF unknown		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) Virginia (State)	
DATE REC'D BY LOCAL REG. 21 Nov 55		REGISTRAR'S SIGNATURE W. L. SAYLOR, 1/Lt MSC		24. FUNERAL DIRECTOR WM COOK, INC. BALTO., MD		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 28 1955

RECEIVED

10439

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10439

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>A. A.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>#</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	
TOWN <u>Laurel</u>	<u>3 hrs.</u>	TOWN <u>Baltimore</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Race Track</u>		STREET ADDRESS (If rural, give location) <u>3306 Spaulding Ave.</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Bertha May Riley</u>		<u>Nov. 1st 1955</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 2, 1887</u>
9. AGE last birthday: <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>✓</u>	11. BIRTHPLACE (State or foreign country): <u>Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Aquilla Wilson</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Holiday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>9-</u>	
17. INFORMANT & ADDRESS:			

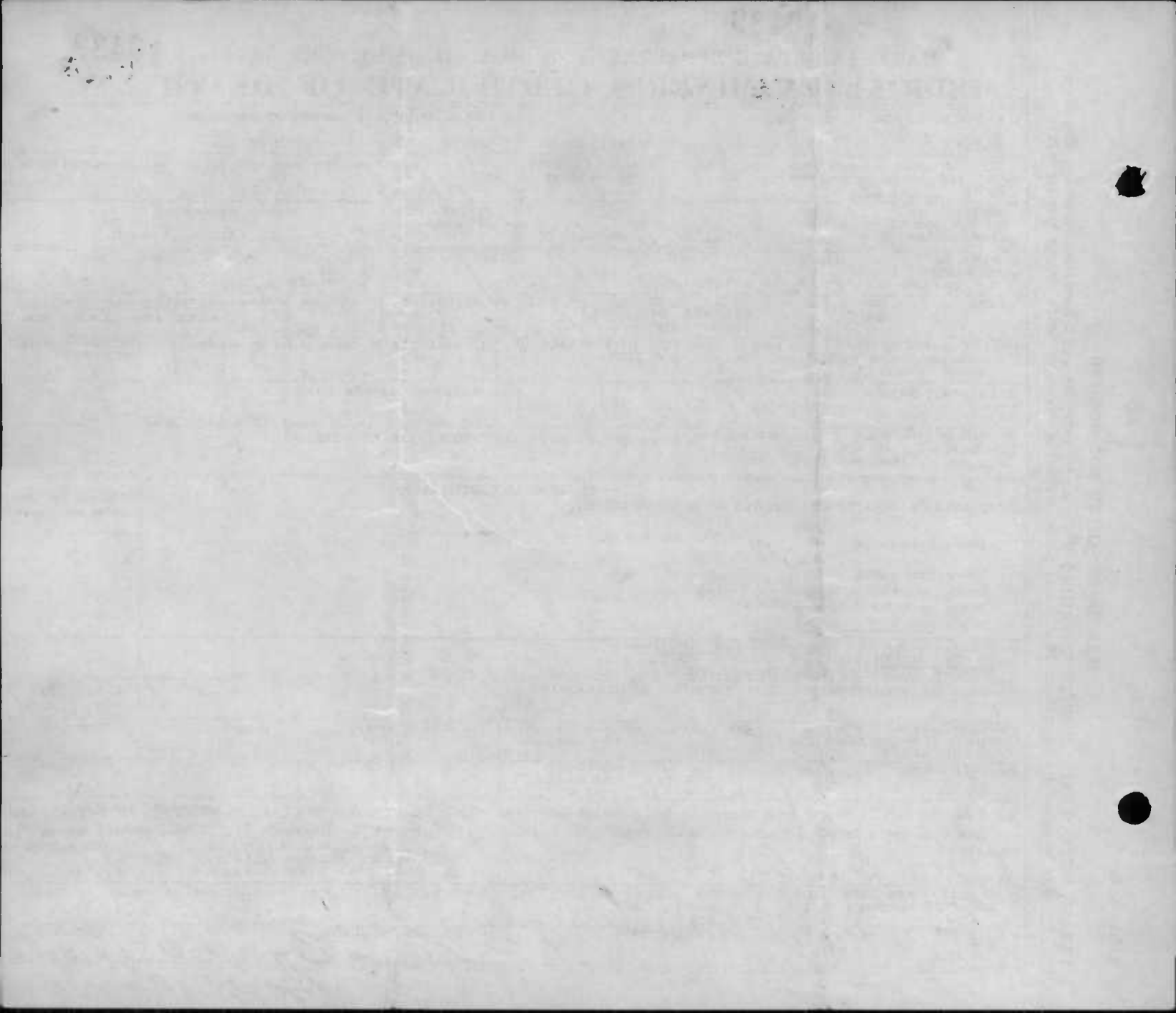
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
420.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO		<u>Sudden</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>0</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Kurtz R. Paulsen</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11/1/55</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		M. D. ASSISTANT MEDICAL EXAM. <u>11/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>11-4/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Chesapeake</u>	LOCATION (City, town, or county) (State): <u>Centerville Md.</u>
DATE REC'D BY LOCAL REG. <u>11/2/55</u>	REGISTRAR'S SIGNATURE: <u>A.W. Hedrick</u>	24. FUNERAL DIRECTOR: <u>Long & Byers 5005 E. Light</u>	
		ADDRESS: <u>Balto 15, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10399 CERTIFICATE OF DEATH

10440

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Ala.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Ala.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
TOWN				STREET ADDRESS (If rural give location) <u>11 N. Brewer Ave.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>Caroline Rebecca Russell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11-8-1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>		8. DATE OF BIRTH <u>3-26-1879</u>	
9. AGE last birthday <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>Basil Gates</u>		14. MOTHER'S MAIDEN NAME <u>Anna Garner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Caroline Gates Russell (2)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arterial Sclerosis & Hypertension</u>				<u>Months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Nephrosis</u>				<u>Years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Several</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 17, 1954</u> , to <u>Nov 8, 1955</u> , that I last saw the deceased alive on <u>Nov 8, 1955</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Oliver Purvis</u>				ADDRESS (Street, city, town, state) <u>Annapolis Md.</u>			
DATE SIGNED <u>11/10/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Annes</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 11, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md.</u>	

DEPARTMENT OF HEALTH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL ISSUE A CERTIFICATE OF DEATH TO THE NEXT OF KIN OR TO THE PERSON IN CHARGE OF THE BURIAL. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL ISSUE A CERTIFICATE OF DEATH TO THE NEXT OF KIN OR TO THE PERSON IN CHARGE OF THE BURIAL. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL ISSUE A CERTIFICATE OF DEATH TO THE NEXT OF KIN OR TO THE PERSON IN CHARGE OF THE BURIAL.

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF NEXT OF KIN

11. SIGNATURE OF BURIAL CHURCH

12. SIGNATURE OF BURIAL SOCIETY

13. SIGNATURE OF BURIAL SOCIETY

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF BURIAL SOCIETY

17. NAME OF PHYSICIAN

18. NAME OF REGISTRAR

19. NAME OF NEXT OF KIN

20. NAME OF BURIAL CHURCH

21. NAME OF BURIAL SOCIETY

22. NAME OF BURIAL SOCIETY

23. NAME OF BURIAL SOCIETY

24. NAME OF BURIAL SOCIETY

25. NAME OF BURIAL SOCIETY

26. NAME OF BURIAL SOCIETY

27. NAME OF BURIAL SOCIETY

28. NAME OF BURIAL SOCIETY

29. NAME OF BURIAL SOCIETY

BUREAU V. 2

NOV 15 1917

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10440 CERTIFICATE OF DEATH

10441

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		STATE <u>MARYLAND</u>		STATE <u>Same</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Leinthicum</u>		<u>40 yrs.</u>		TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Medora + Viewing Care.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Julie (Julia) (Elizabeth) Sachse</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 30 1955</u>			
5. SEX <u>X</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Oct. 23 1881</u>	
9. AGE last birthday <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Arthur Sachse</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Rinehart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-01-3318</u>		17. INFORMANT'S ADDRESS <u>Wm Griffin</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days -</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>				<u>6 yrs -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Epilepsy</u>				<u>2 mos -</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/28/55</u>, 19<u>55</u>, to <u>11/30</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/30</u>, 19<u>55</u>, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball</u>		DATE THEREOF <u>12-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Ritchie Hwy.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		REGISTRAR'S SIGNATURE <u>Dr. Caldwell Woodruff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund Foulson</u>		DATE SIGNED <u>11/30/55</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
DATE <u>DEC 2 1955</u>							

12.4

BUREAU V. S.

DEC 2 1955

RECEIVED

10441 CERTIFICATE OF DEATH

Reg. Dist. No. 10442

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Severna Park
 LENGTH OF STAY (in this place) 11 yrs
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 409-Rt 2, Severna Park

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel
 CITY (If outside corporate limits, write RURAL and give nearest town) Severna Park
 STREET ADDRESS (If rural give location) Box 409-Rt 2, Severna Park

3. NAME OF DECEASED:

(First) AMY (Middle) (none) (Last) SCHICKNER

4. DATE OF DEATH: (Month) November (Day) 5 (Year) 1955

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

17 July 1898

9. AGE last birthday:

57 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

none. Home.

11. BIRTHPLACE (State or foreign country):

Osallona, Iowa

12. CITIZEN OF WHAT COUNTRY?

Yes

13. FATHER'S NAME:

George Wm. Weber

14. MOTHER'S MAIDEN NAME:

Julie Nagle

15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.)

no

16. SOCIAL SECURITY No.:

219-16-4131

17. INFORMANT & ADDRESS:

Henry Schickner (husb) Box 409 Severna Park, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

290.0
 Immediate cause

(a) Acute coronary thrombosis
 DUE TO

Interval Between Onset And Death

1 day

Antecedent causes (s)
 Diseases or conditions, if any,
 giving rise to the above cause
 stating the underlying cause last.

(b) Arteriosclerosis
 DUE TO

5 yrs

(c) Pernicious anemia
 DUE TO

2 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Postero-lateral sclerosis2 yrs

19a. DATE OF OPERATION:

none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

none

PLACE (Home, farm, factory, street, office, etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

INJURY OCCURRED
 While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 14, 1955, to Nov. 5, 1955, that I last saw the deceased

alive on Nov. 2, 1955, and that death occurred at Nov. 5, 1955, from the causes and on the date stated above.

SIGNATURE H. F. Manuzak M.D.

(Degree or title) 901 Edgely Rd, Glen Burnie, Md.

DATE SIGNED Nov. 5, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Nov. 9, 1955

NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

LOCATION (City, town, or county) (State)

Frederick Ave. Balto. Md.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

A. W. Hauch

24. FUNERAL DIRECTOR

ADDRESS

KRAUSE FUNERAL HOME 1216S. Charles St.Balto. 30

1910

1910

10443

10400 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL		STATE MARYLAND		COUNTY ANNE ARUNDEL			
CITY OR TOWN ANNAPOLIS		LENGTH OF STAY (in this place) LIFE		CITY OR TOWN ANNAPOLIS			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3 CARVER STREET		STREET ADDRESS 3 CARVER STREET		(If rural give location)			
3. NAME OF DECEASED (Type or Print) GEORGIANA				4. DATE OF DEATH 11/10/1955			
(First) (Middle) (Last)				(Month) (Day) (Year)			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED		8. DATE OF BIRTH 5/6/1888	
9. AGE last birthday 67 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES HOWARD				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS WILLIAM SIMMS*3 CARVER ST.*ANNAPOLIS			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Interventive atherosclerotic heart disease							
ANTECEDENT CAUSE(S) DUE TO (B) Coronary atherosclerotic disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Grade 2 HT						2 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 13, 1933 , to Nov 10, 1955 , that I last saw the deceased alive on Nov 10, 1955 , and that death occurred at 1:03 P.M. , from the causes and on the date stated above.							
SIGNATURE Ruth K. Hicks		M.D. 110 - Bay St. Annapolis, Md.		ADDRESS (Street, city, town, state) WEST ST. ANNAPOLIS, Md.		DATE SIGNED 11/15/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11/15/1955		NAME OF CEMETERY OR CREMATORY BREWER HILL CEMETERY		LOCATION (City, town, or county) (State) WEST ST. ANNAPOLIS, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ETHEL L. HICKS		ADDRESS 45 NORTHWEST ST. ANNAPOLIS	
DATE Nov. 14, 1955							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH
10442 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10444

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Anne Arundel County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> A.A. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Glen Burnie, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md. (P.O.)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In the woods, Solly Road, Freetown</u>		STREET ADDRESS <u>Solly Road, Freetown</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Margaret</u>			<u>Simms</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1897</u>
9. AGE last birthday <u>58</u> yrs.		4. DATE OF DEATH <u>Nov. 25 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Green</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Thomas Denis Simms</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<u>795.3</u> Immediate cause (a) <u>Unknown (See reverse side)</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Deputy</u>	ADDRESS <u>Glen Burnie, Md.</u>	DATE SIGNED <u>Nov. 25, 1955</u>
----------------------------	------------------------------------	-------------------------------------

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11/30/1955</u>	<u>MT. AUBURN CEMETERY</u>	<u>BALTIMORE, M.D.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>11/28/55</u>		<u>ARLINGTON S. PHILLIPS</u>	<u>1808 N. MONROE ST.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The body of Margaret Simms (deceased) was found decomposed and beyond recognition in the woods 75 yards from her home. She was identified by her husband, Thomas Dennis Simms, by her shoes and her dress. According to the husband she had been missing since Labor Day, 1955.

Gustave H. Baubert

10445

MARYLAND STATE DEPARTMENT OF HEALTH
10443 CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

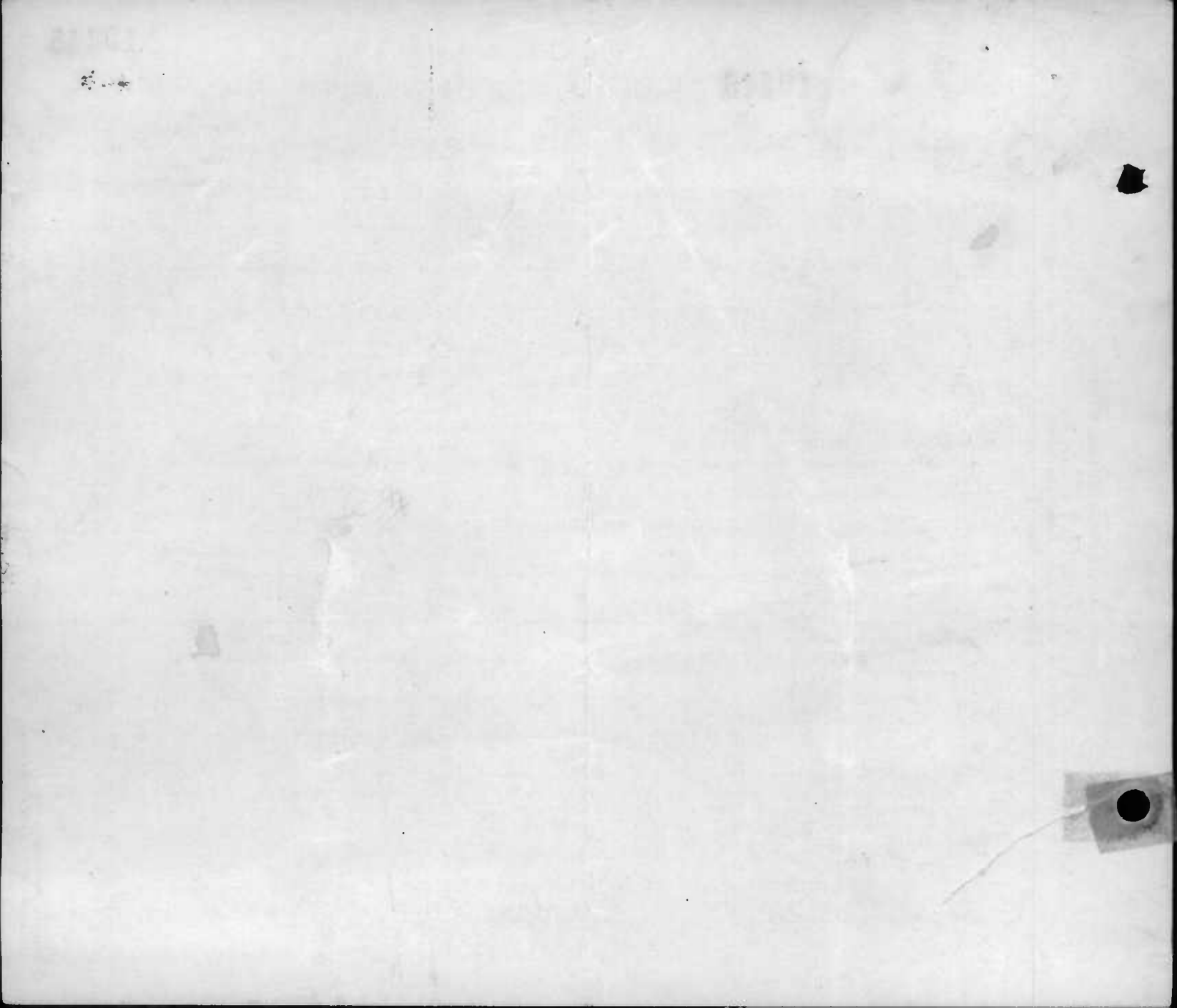
Item 7, Film G188 11-10-55 et

Reg. Dist. No. 23

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Glen Burnie</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glen Burnie High School</u>		STREET ADDRESS (If rural, give location) <u>308 Elchester Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>Jefferson</u> (Last) <u>Smallwood</u>		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>1st</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/29/02</u>
9. AGE last birthday <u>53</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Smallwood</u>		14. MOTHER'S MAIDEN NAME <u>Martha Lambert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>E. H. James, 2831 N. Howard St</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Occlusion</u>		<u>Sudden</u>	
Antecedent cause(s) (b) <u> </u>		<u> </u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>		<u> </u>	
II. OTHER SIGNIFICANT CONDITIONS		<u> </u>	
Conditions contributing to the death but not related to the disease or condition causing death.		<u> </u>	
19a. DATE OF OPERATION <u> </u>	19b. MAJOR FINDINGS OF OPERATION <u> </u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u> </u>	(CITY OR TOWN) <u> </u>	(COUNTY) <u> </u> (STATE) <u> </u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u> </u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Walter B. Paulsen, M.D.</u> (Degree or title)		ADDRESS <u>Medical Examiner, Glen Burnie Md.</u> DATE SIGNED <u>11/1/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>11/5/55</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) <u>Woodlawn, Maryland</u> (State) <u> </u>
DATE REC'D BY LOCAL REG. <u>11/5/55</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. Cook Inc.</u>	ADDRESS <u>1217 St Paul St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

10401 CERTIFICATE OF DEATH

10445

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>A.A. Co.</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>A.A. Co.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>	STREET ADDRESS (If rural give location) <u>18 Parole ST</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) <u>BABY</u> <u>SMITH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11</u> <u>1</u> <u>1955</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>11-1-55</u>
9. AGE last birthday yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>SAMUEL SMITH</u>		14. MOTHER'S MAIDEN NAME <u>LAURA HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT & ADDRESS <u>ANNAPOLIS</u> <u>SAMUEL SMITH - 18 Parole ST</u>
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 776X IMMEDIATE CAUSE (A) <u>Underdevelopment</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Premature delivery</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) STATING UNDERLYING CAUSE LAST.			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-1-55</u> , 19 <u>55</u> , to <u>11-1-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-1-55</u> , 19 <u>55</u> , and that death occurred at <u>5:28</u> M. from the causes and on the date stated above. SIGNATURE <u>G. T. Allen</u> ADDRESS (Street, city, town, state) <u>62 Cathedral ST</u> DATE SIGNED <u>11-1-55</u> M. D. <u>62 Cathedral ST</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-2-55</u>	NAME OF CEMETERY OR CREMATORY <u>Fowler</u>
LOCATION (City, town, or county) <u>Best Gate md</u>		(State) <u>md</u>	
24. REC'D BY REGISTRAR <u>Nov. 14, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u> ADDRESS <u>108 Wash. ST</u>	
REGISTRAR'S SIGNATURE <u>10 X 332199V</u>		ADDRESS <u>ANNAPOLIS, md</u>	

10444 CERTIFICATE OF DEATH

Reg. Dist. No. 10447

1. PLACE OF DEATH:

COUNTY Brown County MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Curtis Bay LENGTH OF STAY 25 OR ? (in this place)
 TOWN Curtis Bay
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Brown
 CITY (If outside corporate limits, write RURAL and give nearest town) Curtis Bay
 OR TOWN Curtis Bay
 STREET ADDRESS (If rural, give location) Hawkins Point Road

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

LOUISSMITH SR

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Nov 181955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MWMOct 20, 187976 yrs.27 Months27 Days27 Hours27 Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

MerchantShippingPennsylvaniaU.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

YesMerchantWife

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
 Immediate cause

(a)

DUE TO

Antecedent causes (s)
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Cornary thrombosisCornary sclerosis

Interval Between Onset And Death

6 weeksyears

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertension?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 3, 1955, to Nov 18, 1955, that I last saw the deceased

alive on Nov 13, 1955, and that death occurred at 7:15 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Louis P. Tumbly M.D.1014 St Paul St11/18/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

November 19, 1955R.W.McClary Funeral Home130 E. Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1010

1010

1

0402 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ANNE ARUNDEL MARYLAND		STATE		COUNTY ANNE ARUNDEL		STATE	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
TOWN ANNAPOLIS		7 DAYS		TOWN EPPING FOREST		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)		1	
63 ANNE ARUNDEL CO GEN HOSP				RTD #1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
HARRY HOUSE SPENCER				NOV. 3, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	MARRIED	OCT 17, 1873	82 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cabinet maker		Bldg. Trades		Peterborough, England		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jack House Spencer				Eliza Spencer.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Verna Jane Spencer, Epping Forest, Annapolis, Md. R. F. D. #1.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) CORONARY OCCLUSION						3 WKS	
ANTECEDENT CAUSE(S) DUE TO (B) ARTERIOSCLEROTIC HEART DISEASE						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 10-28, 1955, to 3 NOV, 1955, that I last saw the deceased alive on 2 NOV, 1955, and that death occurred at 9:25 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Edward Beck				44 Sweetgate Ave Annapolis		11/3/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Nov. 7, 1955		Glenwood Cemetery		Washington, D. C.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE Nov. 8, 1955		J. Arthur Walters		254 Carroll St. N. W. Takoma Park 12, D. C.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10442

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. CAUSE OF DEATH

11. DISEASE OR INJURY

12. MEDICAL HISTORY

13. PRESENT ILLNESS

14. TREATMENT

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF WITNESS

17. SIGNATURE OF DECEASED

18. SIGNATURE OF REGISTRAR

19. DATE OF REGISTRATION

20. PLACE OF REGISTRATION

21. OFFICE OF REGISTRAR

22. COUNTY OF DEATH

23. STATE OF DEATH

24. CITY OF DEATH

25. ZIP CODE

26. COUNTY OF BIRTH

27. STATE OF BIRTH

28. CITY OF BIRTH

29. ZIP CODE

30. COUNTY OF DEATH

31. STATE OF DEATH

32. CITY OF DEATH

33. ZIP CODE

34. COUNTY OF BIRTH

35. STATE OF BIRTH

36. CITY OF BIRTH

37. ZIP CODE

38. COUNTY OF DEATH

39. STATE OF DEATH

40. CITY OF DEATH

41. ZIP CODE

42. COUNTY OF BIRTH

43. STATE OF BIRTH

44. CITY OF BIRTH

45. ZIP CODE

46. COUNTY OF DEATH

47. STATE OF DEATH

48. CITY OF DEATH

49. ZIP CODE

50. COUNTY OF BIRTH

51. STATE OF BIRTH

52. CITY OF BIRTH

53. ZIP CODE

54. COUNTY OF DEATH

55. STATE OF DEATH

56. CITY OF DEATH

57. ZIP CODE

58. COUNTY OF BIRTH

59. STATE OF BIRTH

60. CITY OF BIRTH

61. ZIP CODE

62. COUNTY OF DEATH

63. STATE OF DEATH

64. CITY OF DEATH

65. ZIP CODE

66. COUNTY OF BIRTH

67. STATE OF BIRTH

68. CITY OF BIRTH

69. ZIP CODE

70. COUNTY OF DEATH

71. STATE OF DEATH

72. CITY OF DEATH

73. ZIP CODE

74. COUNTY OF BIRTH

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78. COUNTY OF DEATH

79. STATE OF DEATH

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81. ZIP CODE

82. COUNTY OF BIRTH

83. STATE OF BIRTH

84. CITY OF BIRTH

85. ZIP CODE

86. COUNTY OF DEATH

87. STATE OF DEATH

88. CITY OF DEATH

89. ZIP CODE

90. COUNTY OF BIRTH

91. STATE OF BIRTH

92. CITY OF BIRTH

93. ZIP CODE

94. COUNTY OF DEATH

95. STATE OF DEATH

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97. ZIP CODE

98. COUNTY OF BIRTH

99. STATE OF BIRTH

100. CITY OF BIRTH

101. ZIP CODE

102. COUNTY OF DEATH

103. STATE OF DEATH

104. CITY OF DEATH

105. ZIP CODE

106. COUNTY OF BIRTH

107. STATE OF BIRTH

108. CITY OF BIRTH

109. ZIP CODE

110. COUNTY OF DEATH

REGISTRATION

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE PRODUCED TO ANY COURT OF LAW OR TO ANY OFFICIAL OF THE STATE OF MARYLAND WHO MAY REQUIRE IT. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE PRODUCED TO ANY COURT OF LAW OR TO ANY OFFICIAL OF THE STATE OF MARYLAND WHO MAY REQUIRE IT.

BUREAU V. S.

NOV 9 1908

RECEIVED

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10449

10403 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>10 Annapolis</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>13 Green Haven (Parakee P.O.)</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>13 Anne Arundel General Hospital</i>				STREET ADDRESS (If rural give location) <i>Rt 3, Box 349</i>			
3. NAME OF DECEASED (Type or Print) <i>MALUCHI (none) TIERNAN</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov. 20 19 55</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>June 21-55</i>	9. AGE last birthday <i>0</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>yes</i>	
13. FATHER'S NAME <i>WILLIAM TIERNAN</i>				14. MOTHER'S MAIDEN NAME <i>Louella Tiernan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Wm Tiernan</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>340.0 acute purulent meningitis - organism unknown</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized systemic infection - influenza</i>						<i>7 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>None</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION <i>autopsy - As stated above (18-A)</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July</i> , 19 <i>55</i> , to <i>Nov. 20</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Nov. 20</i> , 19 <i>55</i> , and that death occurred at <i>5:50 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>H. F. Manuzak</i>				ADDRESS (Street, city, town, state) <i>901 Edgerly Rd. Hls. Bonnie, Md.</i>		DATE SIGNED <i>11-20-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE OF REEF <i>Nov 22 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>		LOCATION (City, town, or county) <i>Brooklyn Ind</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Am. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard G. Tint</i>		ADDRESS <i>Hls. Bonnie Md</i>	
DATE <i>Nov 22, 1955</i>							

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10450

10445 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>—</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ft Geo G Meade</u>		<u>10 months</u>		TOWN <u>Baltimore</u>		<u>3001-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural give location)			
<u>560</u> <u>U.S. Army Hospital</u>		<u>2725 Maryland Avenue</u>					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Paul Eldridge Trumps</u>				<u>November 8 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>White</u>	<u>single</u>	<u>8 November 1955</u>				<u>2 55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>—</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Shirley Ray Trumps</u>				<u>Katherine Ann Herbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Mother: 1401 Saunders Way, Glen Burnie, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>560.4</u> <u>Atelectasis, bilateral</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 55 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diaphragmatic hernia, left</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Herniation of small bowel, large bowel to</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>descending colon, left lobe of liver, spleen, pancreas into left thoracic cavity.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>0150 8 Nov, 19 55</u> , to <u>0445 8 Nov 19 55</u> , that I last saw the deceased alive on <u>0445 8 Nov 19 55</u> , and that death occurred at <u>0445</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George Norman Schultz, M.D.</u>				DATE SIGNED <u>8 Nov 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9 Nov 55</u>		<u>Post Cemetery</u>		<u>Ft GG Meade, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>8 Nov 55</u>		<u>W. L. SAYLOR, 1/LT MSC</u>		<u>Chaplain Russell, Ft GG Meade, Md.</u>			

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10404 CERTIFICATE OF DEATH

10451

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>317 West St</u>		STREET ADDRESS (If rural give location) <u>317 West St</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>CHARLES THOMAS WALTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 31 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR. 20, 1892</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Walton</u>				14. MOTHER'S MAIDEN NAME <u>Rose Stallings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Clara Greenwell, 317 West St Annapolis</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>coronary thrombosis</u>						2 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic cardio-vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>gen. arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>55</u> , to <u>Nov. 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>55</u> , and that death occurred at <u>5 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>S. J. Borroughs</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>11/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Friendship, Md.</u>	
24. REC'D BY REGISTRAR <u>Nov. 30, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O. Hardisty</u>		ADDRESS <u>Haleville Md</u>	

CERTIFICATE OF DEATH

10451

Reg. Dist. No. 10

1. DEATH NUMBER FOR REPORT OF DEATH

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF CLERK

23. SIGNATURE OF ASSISTANT CLERK

24. SIGNATURE OF RECEPTIONIST

25. SIGNATURE OF TELEPHONE OPERATOR

26. SIGNATURE OF MAIL ROOM

27. SIGNATURE OF RECORDS SECTION

28. SIGNATURE OF STATISTICS SECTION

29. SIGNATURE OF LABORATORY

30. SIGNATURE OF X-RAY DEPARTMENT

31. SIGNATURE OF RADIOLOGY

32. SIGNATURE OF PATHOLOGY

33. SIGNATURE OF BACTERIOLOGY

34. SIGNATURE OF VIROLOGY

35. SIGNATURE OF IMMUNOLOGY

36. SIGNATURE OF EPIDEMIOLOGY

NOTIFICATION

1. DEATH NUMBER FOR REPORT OF DEATH
2. PLACE OF DEATH
3. NAME OF DECEASED
4. SEX
5. AGE
6. DATE OF BIRTH
7. PLACE OF BIRTH
8. OCCUPATION
9. CAUSE OF DEATH
10. MANNER OF DEATH
11. TIME OF DEATH
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESSES
15. SIGNATURE OF DECEASED
16. SIGNATURE OF NEXT OF KIN
17. SIGNATURE OF BURIAL OFFICIAL
18. SIGNATURE OF CHURCH OFFICIAL
19. SIGNATURE OF FUNERAL HOME
20. SIGNATURE OF CEMETERY
21. SIGNATURE OF INTERVIEWER
22. SIGNATURE OF CLERK
23. SIGNATURE OF ASSISTANT CLERK
24. SIGNATURE OF RECEPTIONIST
25. SIGNATURE OF TELEPHONE OPERATOR
26. SIGNATURE OF MAIL ROOM
27. SIGNATURE OF RECORDS SECTION
28. SIGNATURE OF STATISTICS SECTION
29. SIGNATURE OF LABORATORY
30. SIGNATURE OF X-RAY DEPARTMENT
31. SIGNATURE OF RADIOLOGY
32. SIGNATURE OF PATHOLOGY
33. SIGNATURE OF BACTERIOLOGY
34. SIGNATURE OF VIROLOGY
35. SIGNATURE OF IMMUNOLOGY
36. SIGNATURE OF EPIDEMIOLOGY

BUREAU V. S.

RECEIVED

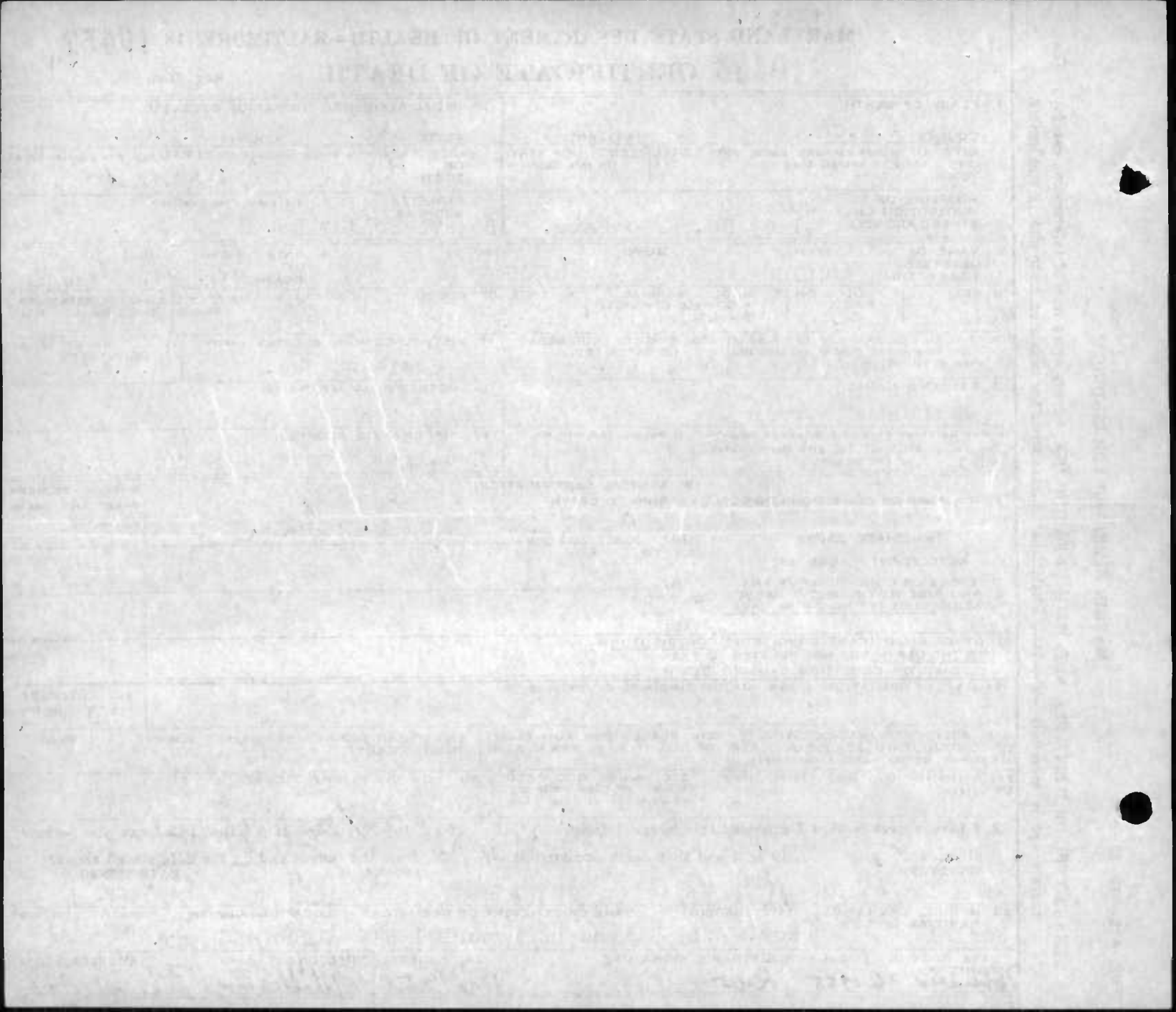
10446 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>A.A.Co.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>A.A.Co.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> <u>X</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> Box 276 Solley Rd. & Ivy Ave.		STREET ADDRESS (If rural give location) Box 276 Solley Rd. & Ivy Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last) JULIUS B. WARREN		4. DATE (Month) (Day) (Year) OF DEATH: Nov. 24, 19 55	
5. SEX: Male	6. COLOR OR RACE: Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: Sept. 12, 1880
9. AGE last birthday: 75 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Gas Co.	
11. BIRTHPLACE (State or foreign country): Galesville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Nathan Warren		14. MOTHER'S MAIDEN NAME: Louise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: Cecelia Warren Box 276 Solley Rd. & Ivy			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 420.1			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12, 1953, to 9/24, 1953 that I last saw the deceased alive on 9/23, 1953, and that death occurred at 11 AM, from the causes and on the date stated above.			
SIGNATURE <u>B M Rhetta</u>		DATE SIGNED <u>9/26 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 27, 1953	
NAME OF CEMETERY OR CREMATORY Arbutus Memorial P		LOCATION (City, town, or county) Arbutus Md.	
DATE REC'D BY LOCAL REGISTRAR 26 1955		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Mr. Katie R. Williams</u>		ADDRESS <u>322 N. E. Howard St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A190-1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10453

10405 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>A.A.</u>	MARYLAND	STATE <u>Mo.</u>	COUNTY <u>A.A. Co.</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ANNAPOLIS</u>		TOWN <u>EDGEWATER</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>A.A. GENERAL Hospt.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>Van</u> (First) <u>ORDEN T.</u> (Middle) <u>WIER</u> (Last)		<u>11</u> (Month) <u>22</u> (Day) <u>1955</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>2/16/1877</u>
		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
			Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WOODWORK</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>RICHARD T. WIER</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. THRUSH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <u>THOMAS E. LEE MAYO, MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>		<u>2 yds.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 10, 1953</u> , to <u>Nov. 23, 1955</u> , that I last saw the deceased alive on <u>11-23-55</u> , and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.			
SIGNATURE <u>James R. Martin</u>		DATE SIGNED <u>11/24/55</u>	
M.D. <u>Annapolis, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>Davidsonville, Md.</u>	
DATE THEREOF <u>11/25/55</u>		LOCATION (City, town, or county) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>JO - U. S. Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>	
DATE <u>Nov. 25, 1955</u>		ADDRESS <u>Annapolis, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10447
Items 18422 Film 6193; 12-20-55 and

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10454
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 27

I. PLACE OF DEATH:

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Ft. Geo. G. Meade, Md.

LENGTH OF STAY (in this place)

few instants

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Ft. George G. Meade Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Prince Georges

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Laurel, Md.

1641x2

STREET ADDRESS

(If rural, give location)

344 Main Street

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Dorothy

Karen

Willow

4. DATE OF DEATH

(Month)

(Day)

(Year)

Nov. 11,

19 55

5. SEX:

F

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Single

8. DATE OF BIRTH:

Oct. 29, 1955

9. AGE last birthday:

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

none

10b. KIND OF BUSINESS OR INDUSTRY:

none

11. BIRTHPLACE (State or foreign country):

Ft. Meade Hospital - Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

William H. Willow

14. MOTHER'S MAIDEN NAME:

Dorothy Terrell Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Mrs. D. T. Willow (mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

983x
Immediate cause

(a) DUE TO

Ligature strangulation

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE

[Signature]

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

11-12-55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Nov 15, 1955

NAME OF CEMETERY OR CREMATORY

Ft. Meade

LOCATION (City, town, or county)

Ft. Meade, Prince Georges Co., Md.

(State)

DATE REC'D BY LOCAL REG

NOV 15 1955

REGISTRAR'S SIGNATURE

[Signature]

24. FUNERAL DIRECTOR

[Signature]

ADDRESS

[Signature]

BUREAU V. S.

NOV 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10455

10448 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> <u>Crownsville</u> <u>MARYLAND</u>				STATE <u>Baltimore</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis, Maryland</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore city, Maryland</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS <u>1610 Durham Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>George</u> <u>Wingate</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 26, 1955</u> <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>	8. DATE OF BIRTH <u>2-13-?</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Private Industry</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Samuel Wingate</u>				14. MOTHER'S MAIDEN NAME <u>Ienson ? Wingate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Cora Wingate</u> <u>wife</u> <u>1610 Durham St.</u> <u>Baltimore, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>each day</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>April, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cataract Removal</u> <u>No Complications</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/17/54</u> , 19....., to <u>11/26/55</u> , 19....., that I last saw the deceased alive on <u>11/26/55</u> , 19....., and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Leon W. White M.D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville State Hospital</u>		DATE SIGNED <u>11/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
24. REC'D BY REGISTRAR <u>1501 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Williams</u>		ADDRESS <u>1701 N. Bond St.</u>	

DEC 1 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10449

CERTIFICATE OF DEATH

10456

28

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>42 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>		<u>3401.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>4405 St. George Avenue</u>		✓	
3. NAME OF DECEASED (Type or Print) <u>Maggie</u> (First) (Middle) (Last) <u>Wright</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11</u> <u>21</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>80?</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>434.1</u> IMMEDIATE CAUSE (A) <u>Congestive cardiac failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Complete heart block</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic heart disease</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>---</u>		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/10</u> <u>1955</u> , to <u>11/21</u> , <u>1955</u> , that I last saw the deceased alive on <u>11/21</u> , <u>1955</u> , and that death occurred at <u>10:25 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict</u> (L. Benedict, M. D.)				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>11/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ambrose</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Latherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Hill</u>		ADDRESS <u>1631 Mount Hill Ave.</u>	
DATE <u>NOV 23 1955</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES H. HARRIS		Male		45		White		11/22/55		Home	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH		10. DATE OF BIRTH		11. SEX OF BIRTH		12. RACE OF BIRTH	
Myocardial infarction		Natural		Baltimore, Md.		11/22/10		Male		White	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 25 1955

RECEIVED

12-21-55

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10450 CERTIFICATE OF DEATH

10457

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> LENGTH OF STAY (in this place) <u>17 yrs. 25 days</u> TOWN <u>Crownsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore City</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> TOWN <u>Baltimore City</u> STREET ADDRESS (If rural give location) <u>None given</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Dudd</u> <u>Young</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11</u> <u>1</u> <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE last birthday <u>49?</u> yrs.		10. AGE last birthday <u>49?</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Jim Young</u>		14. MOTHER'S MAIDEN NAME <u>Sue Willis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002 X</u>			
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u> Known to us since <u>6/13/50</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Post Encephalitic Parkinsonism</u> Known to us since <u>10/7/38</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>6/29</u> , 19 <u>51</u> , to <u>11/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/1</u> , 19 <u>55</u> , and that death occurred at <u>8:45a</u> M, from the causes and on the date stated above. SIGNATURE <u>Stanley C. Sargeant</u> M.D. ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>11/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>NOV 7-55</u>	
NAME OF CEMETERY OR CREMATORY <u>U of M. MED. SCHOOL GREEN &</u>		LOCATION (City, town, or county) (State) <u>GREEN &</u>	
24. REC'D BY REGISTRAR <u>Katherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Deffel Bros</u>	
DATE <u>Nov. 9, 1955</u>		ADDRESS <u>1200 FLORENCE AVE</u>	

